- *The Truth About Fee-Splitting*
- *General Practitioners on the Staff*
- *Practical Nurse Training*

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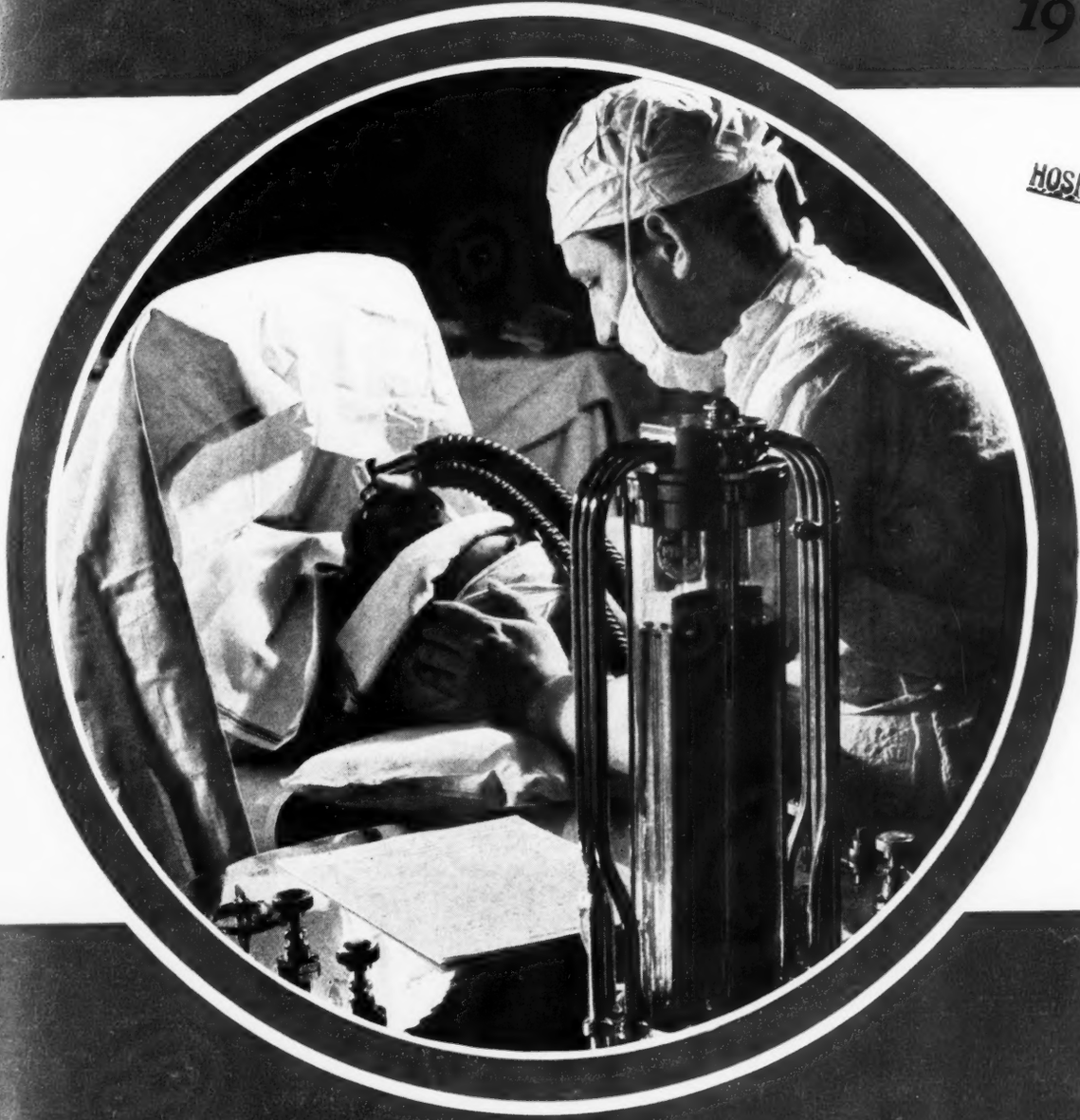



# The Modern Hospital


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*. . . Small wonder there are more Sloan Flush Valves sold than all other makes combined.*

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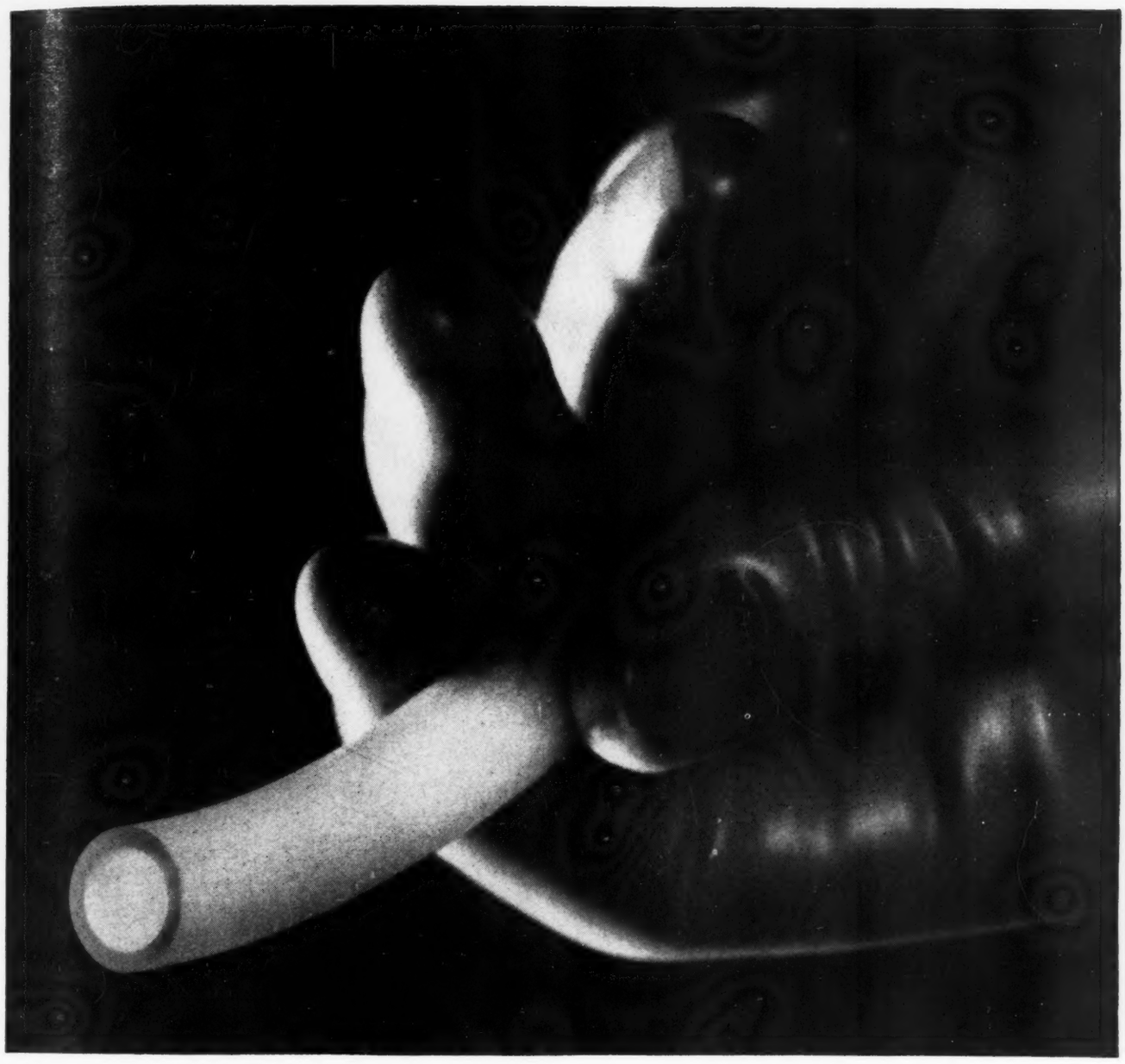

# Let's look into this intravenous tubing question

## *A typical example of B.F.Goodrich product development*

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# *In this issue:*



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# AMONG THE AUTHORS

**George H. Buck,** administrator of the Mercer Hospital at Trenton, N.J., is president of the New Jersey Hospital Association and chairman of the safety committee of the A.H.A. Council on Plant Operation and Maintenance. A graduate of the University of Chicago's course in hospital administration with the initial class of 1934, Mr. Buck served an administrative internship at Massachusetts General Hospital in Boston. Before going to the Mercer Hospital ten years ago, Mr. Buck held assistantships at Lenox Hill Hospital, New York City, and Long Island College Hospital in Brooklyn.

**James T. McGibony, MD.,** is a lieutenant colonel in the medical corps, U.S. Army, now serving as commanding officer of the hospital described in his article on page 49, Tripler General at Honolulu. A brother of Dr. John R. McGibony, assistant chief of the Hospital Facilities Division, U.S. Public Health Service, the army's Dr. McGibony is a graduate of Emory University Medical School at Atlanta, Ga., and the Army Medical School in Washington, D.C. During the war, he served in the surgeon general's office as chief of the hospital administration branch and, later, the hospital division. He was awarded the Legion of Merit and the Commendation Ribbon for his work in army hospital administration.

**Paul F. Woolrich** is a graduate of the University of Texas School of Mechanical Engineering, with a master's degree in sanitary engineering from the same school. A member of the sanitary engineering staff of the Texas State Health Department, Mr. Woolrich has been working for several months with the department's industrial hygiene section in an effort to improve air conditioning facilities in hospital nurseries throughout the state. He has worked closely with the state hospital planning board.

**Charles E. Duncan** is general storekeeper at the Miami Valley Hospital, Dayton, Ohio. Mr. Duncan started his hospital work several years ago as assistant pharmacist at the hospital and then became storekeeper, in charge of the hospital's buying, receiving, storing, issuing and record keeping. Later, he carried on the same kind of work in the hospital corps of the U.S. Navy.

R. Eilola

M. Hollway

**Rebecca Eilola** is an elementary and recreational teacher on the staff of the University Hospital School at the University of Michigan, Ann Arbor. She is a graduate of Michigan State Normal College and the University of Michigan. . . . **Marian M. Hollway,** co-author with Miss Eilola of the article on projected books on page 79, is teacher-librarian in the social service library at the University Hospital.

# *EDITORIAL BOARD*

# Roving Reporter

## So the Visitor Stayed

These are not the times when hospitals furnish a bed for a patient's friend or guardian. But an exception must be made now and then.

Southside Hospital, Bay Shore, Long Island, N.Y., recently had as a patient Harry Strong, 50 years old. Mr. Strong had a broken shoulder and bruises, the result of being struck by an automobile. If he had not been pulled from the path of the car by a friend, Mr. Strong might have been driven to the undertaker's rather than to the hospital. His rescuer came right along with Mr. Strong and sat down beside his bed. When visiting hours were over and when night came, the friend refused to leave.

After looking the situation over, nobody wanted the job of ousting Mr. Strong's friend. So he stayed on as long as Mr. Strong stayed and he proved quite an attraction.

The friend insisted on remaining in the room with Mr. Strong so he was given a blanket and slept under the bed. During the daytime he was tied to the bedpost. But he and Mr. Strong were content.

The friend, by the way, is a German boxer and that was one reason nobody cared to argue with him. His name is Panzer and he is a Seeing Eye dog.

## They're So Polite

Is it the bunk to think people will dunk more doughnuts because of the pressure publicity of "National Donut Month"? Professional educators profess to think little of these hoop-la "weeks" or "months" although the National Education Association itself sponsors American Education Week every November.

As yet it is too soon to evaluate the staying power of the two week courtesy campaign carried on last November at Mercy Hospital of Hamilton, Ohio. But the campaign did arouse great interest at the time and brought the hospital citywide publicity.

The way the courtesy campaign worked at this hospital (Sr. Mary Benignus is the superintendent) is that every employe was asked to report courteous deeds observed during the fortnight of the campaign. Prizes were then awarded for the most courteous act and to the person reporting it.

Outside the walls even the campaign had its boosters. The local Y.W.C.A. donated the prizes; the girl scouts and the junior high school art pupils made posters. To initiate the campaign several hospital department heads gave talks to employes. The prizes were awarded by the chairman of the local Rotary Club's courtesy contest.

It is cause to wonder whether Rotarian patients in the hospital outdid hospital employes in being courteous to one another.

## Sirup Buys Bed

The men's ward at Heaton Hospital, Montpelier, Vt., has 11 beds. They are new beds now, with gatch springs, fine mattresses and sturdy bedside tables adjacent to them: all by the courtesy of the local Kiwanis Club. The cost was $1200.

To raise the money the Kiwanis Club had two projects. One was an exposition at the city hall in which nearly every business firm in the city had a booth for the display of merchandise. The second scheme would not work so well outside of Vermont but some other local product could be used. The Montpelier Kiwanis Club offered Vermont maple sirup for sale to other Kiwanis Clubs all over the country.

## Food for the Soul

If you have changed your type of food service and don't know what to do with the old food carts, here's a con-

version idea and we're not punning. You can make the old three-tray cart into a portable altar for religious services on the wards. The Veterans Administration hospital at Oteen, N. C., has done this successfully. The cart was covered with draperies and equipped with a portable communion set and now carries food for the soul instead of food for the body.

Patients in the V.A. hospital at Aspinwall, Pa., take part in a weekly Religious Forum, a round table discussion of the history of religion conducted by the hospital chaplain.

A number of V.A. hospitals are showing religious films at chapel services. The two most popular titles are "Suffer, Little Children," a dramatization of the parable of the Prodigal Son, and the "Life of St. Paul."

## Memory of a Good Meal

Hospital patients like to take a few souvenirs home and we don't necessarily mean their gallstones. Those who spend a holiday in Wesley Hospital, Chicago, are likely to tuck in the printed dinner menu when they pack.

Wesley's four page souvenir menu folder is not as expensive as it sounds or looks. L. G. Nelson reports that the hospital buys the necessary number of place mats decorated in two colors with appropriate holiday scenes.

The menu is printed on the reverse side of the place mat to the right. To the left is a holiday message by chaplain or administrator. On the decorated side of the mat the hospital's name, the holiday and the year are printed to the right. Then the mat is given a vertical fold and there's the menu—well worth taking home.

## Volunteers Are Interested

The idea isn't new but it has a ballerina skirt and padded hips look. A lecture series for volunteers means new enthusiasm for the work, even when carried on in a frumpy, styleless way. But Cincinnati General Hospital has designed a lecture demonstration series that is strictly 1947-48.

Leading professors of the University of Cincinnati College of Medicine are giving lecture demonstrations to volunteer nurse's aides on the first Friday of each month. Not only are General Hospital's volunteers welcomed but any hospital volunteers in the county may come. Heightened interest comes from the fact that the lecture demonstrations are held in the amphitheater of the hospital.

The talks and demonstrations are on the following subjects: intravenous injections; early detection of cancer by the smear method; preoperative and postoperative care, including the Wangensteen procedure and oxygen administration; new methods in the treatment of fractures; chest surgery; demonstration of interesting cases; recent advances in obstetrical practice.

Naturally, volunteer nurse's aides do not play a part in such hospital procedures but they see them and hear about them, and to have them discussed and demonstrated by experts is a great compliment to these workers, most of whom are highly intelligent citizens. They spread the enthusiasm thus generated and the knowledge gained to their families and friends. The results are new recruits for volunteer service and public enlightenment.

# READER OPINION

## Nurse Recruitment

Sirs:

The reputation of The MODERN HOSPITAL for editorial accuracy suffers in the December editorial "Expensive Folly."

The implication is that the hospitals are not seeking the active cooperation of the nurses in working out the difficulties involved in providing the nation with adequate nursing service at reasonable cost. Have you heard about the activities of the representatives of nursing, medicine and hospitals on the joint committee which was instigated by the American Hospital Association? Do you know about the interest and active participation by the hospital administrators in the Carnegie study of nursing? The Institute on Nursing on March 1 is conducted jointly by the American Hospital Association and the National League of Nursing Education. Its students will be an equal number of hospital administrators and nurses.

On this question of auxiliary nursing personnel, there was a decrease in the number reported by the American Medical Association between 1945 and 1946, caused by the closing of 280,000 beds in hospitals for the armed forces and the discharge of medical corpsmen serving in this capacity, but the non-federal hospitals increased the average number of patients per day slightly more than 1 per cent and the number of paid auxiliary nursing personnel 19,000, or 15 per cent. From what I know about what is happening it is safe to assume there has been a further marked increase in 1947. Have you been in the labor market recently to try to recruit ward clerks, orderlies and attendants? There has been a marked decrease in the number of volunteer nurses's aides, but their numbers must be discounted heavily in comparison with paid workers.

You criticize hospitals for failing to train practical nurses. A large segment of the nursing profession in many parts of the country resists such training. They may have a point for all I know.

Sooner or later you will learn about the intensive efforts being made *now* to put recruitment of adequate numbers of hospital personnel of all kinds on a permanent and continuing basis.

Graham L. Davis
President
American Hospital Association

Sirs:

The editorial, "Expensive Folly," seems to be immature and rather harshly critical of those who are recruiting student nurses, of nursing, of hospital trustees, of hospital administrators, and certainly a nurse educator. It seems to be written in a rather cynical and sarcastic vein and I feel the sarcasm is not effective when used on such groups as we have mentioned.

I feel that the present nursing crisis is part and parcel of a general crisis in this country which is largely a direct result of the backwash of two wars. We cannot solve it merely by displaying our difficulties before the public. It is a professional problem and we must face it realistically and with sympathy and understanding rather than with sarcasm.

The problem as hospital administrator is to see that we have professional students rather than technicians, in a profession rather than in a trade, and we should find out what means are necessary to ensure that aim and to find the basic needs and problems, one of which seems to be the effective use of nursing time; another is the relative wage scales of industry and those for nurses, and a third, and perhaps most important, the rôle which the nurse plays today in medicine and the hospital.

We should make every effort to see that these young, intelligent, inspired students and recent graduates are helped to maintain that attitude. We older members of the professions can, and I think will, give leadership to the younger members of the nursing profession by example, by our teaching, and by our tenacity in the belief of what constitutes a profession. If we do that, I feel certain that we can bridge the next several years. Then this effect of the backwash of wars, this nursing crisis, will diminish and nursing will emerge stronger than ever before.

F. R. Bradley, M.D.
St. Louis

*"It is good that we suffer sometime contradiction, and that we be holden of others as evil and wretched and sinful, though we do intend well, for such things help us to meekness, and mightily defend us from vainglory and pride."*
*—The Imitation of Christ.*—ED.

# SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

## Soot Is Problem

**Question: What can be done about the problem of soot being scattered over the premises from the hospital smokestack?—J.A.B., N. Y.**

ANSWER: It is not easy to give a short specific answer because the soot problem is tied up with the entire combustion system. The use of proper automatic combustion equipment, automatic draft controls to maintain a proper balance between the positive pressure under the grates and the negative pressure over the fire, is the answer to soot control.

One hospital installed automatic draft control equipment and that, plus the installation of $CO_2$ meters and stack temperature recorders, enabled it to increase overall combustion efficiency from a low of about 58 per cent to an average of 71 per cent. The money spent for equipment was saved in just one heating season.

## What Size Sheet?

**Question: What size sheet do you recommend for general hospital use? I have heard it suggested that the hem of sheets should be the same on both ends. I can see no particular value in having hems the same width on both ends of sheets. What is your opinion about this?—T.D., N. D.**

ANSWER: I recommend 72 by 99 inch sheets at the present, and they were the only ones I could get during the war; however the 72 by 108 inch sheets are gaining favor in many hospitals.

Hems should be the same width on both ends because the wear is more evenly distributed, thereby ensuring longer wear of the sheet. In prewar days one could specify a 1 inch hem at both ends, but with the war and standardization, it was difficult to obtain.—JEWELL W. THRASHER.

## Competitive Bids

**Question: In purchasing, how valuable are competitive bids—if at all?—R.G., T. H.**

ANSWER: The question as to whether or not to obtain competitive bids before purchasing is a controversial one. In general, it would seem to me that if hospitals keep accurate records of yearly consumption on the main items of operating supplies and equipment and then work on a yearly contract basis instead of buying from hand to mouth in small quantities, it would pay to get competitive bids. There is no question but what manufacturers and suppliers could quote lower prices if hospitals placed a firm contract order for a full year's supply of their various principal items.

Many large hotels and chains of hotels do not wait for salesmen to come to take orders but carefully figure out what they need on a yearly basis and ask for competitive bids on a full year's contract order.

## Four Ways to Save

**Question: What can the individual hospital do to reduce costs, or at least level off the upward trend?—T.H.H., Tenn.**

ANSWER: Studies and investigations by the American College of Surgeons and other groups prove definitely that from 50 to 70 per cent of the total bedside nursing hours per patient day can be given by practical nurses with from eight months to one year of training and nurse's aides who have had training similar to that given Red Cross aides during the war. It is well known today that the use of a regular nursing clerk on each unit saves a great deal of the nurse's time. By staffing one nursing department of a 200 bed hospital operating at 80 per cent occupancy on this basis, a saving of approximately $55,000 a year in the nursing department alone was projected. This amounted to about 90 cents per patient day.

Second, hospitals must institute perpetual inventory control and centralized purchasing procedures. If hospitals, on the basis of known facts, will advertise for bids on their main consumable items on a yearly contract basis, they can obtain lower prices. For example, in most instances, hospitals are today paying retail prices for sheets and pillow cases whereas hotels buying in larger quantities pay from 15 to 20 per cent less than hospitals do.

Third, the hospital administrator and pharmacist should work with a standard formulary committee of the professional staff to adopt a standard and simplified formulary for the hospital. Where this has been tried, the items carried in the hospital drug room have dropped from 1200 to 2000 down to 200 or 400. Many small hospitals, even those with as few as 50 beds, are missing a bet by not having a full time registered pharmacist. This pharmacist can, by manufacturing ointments, elixirs and other items and preparing prescriptions, save a great deal of money. In a small hospital, this pharmacist could also act as the central purchasing agent.

Fourth, almost every hospital could, by the installation of automatic draft controls, $CO_2$ meters and stack temperature recorders, effect a saving of anywhere from 15 to 35 per cent on its annual fuel bill.

## Inventory Is Valuable

**Question: At approximately what bed capacity does a perpetual inventory card system become advisable?—J.B., Kan.**

ANSWER: Many arguments have been given pro and con on the subject of perpetual inventories in hospitals. There is no longer any question in the minds of those who have studied the problem carefully, and those who are actually using the perpetual inventory systems, that hospitals of 100 beds and more just cannot afford to operate without such a system. Many authorities feel that the same thing holds true for any hospital no matter how small it is.

At the purchasing section meeting of the New England Hospital Assembly two years ago, the administrator of a hospital of approximately 40 beds testified as to the great value to her of operating such an inventory.—E. W. JONES.

# Looking Forward

## Strike Up the Band

THE Colorado physician who was chosen by his colleagues last month as Practitioner of the Year is unquestionably an admirable character, devoted to his patients and his profession and fully deserving the honor that has been bestowed upon him. In fact, after reading about his career the only fault one can find with his selection as the ideal family doctor is that he doesn't look like Barry Fitzgerald.

Unquestionably, too, the medical leaders were moving right with the times when they decided to hang a medal on the family doc. For years the bright lights of public recognition have been shining on the glamour boys of the operating room and the research lab, while the general practitioner has carried the heavy end of the pole in comparative obscurity.

Recently, there have been disturbing signs that he might drop his end of the pole. In increasing numbers, young doctors have been straining eagerly toward the lights, shunning the outer shadows and scorning to help the practitioner with his burden. For a while there, in fact, the family doctor was being patronized even by his patients, who learn all about medicine in the *Reader's Digest*, which he doesn't have time to read. To exorcise these unhappy omens, the medical equivalent of Hollywood's Oscars has now been introduced.

Professionally fastidious physicians may shudder ever so slightly at this latest hint that the cinema influence is infiltrating their lofty profession. A few may even have nightmares in which the familiar jingle on the radio becomes incessantly, "Old Doc Duz duz ev'rything!"

Such feelings as these, of course, are hopelessly outdated. In our fantastic culture, where Mother's Day is followed by National Bread and Gravy Week, the quiet tones of Virtue are unheard amidst the crashing brasses of Publicity, so Virtue has to hire a horn.

Ready, Doctor? Allegro molto con brio, *fortissimo!*

## Straws in the Whirlwind

ACCORDING to the pitch and fervor of one's political beliefs, President Truman's January message to Congress was either a shrewd summarizing of the nation's needs and the legislature's responsibilities, or a crass attempt to capture votes. In either case it left most of us right where it found us, politically; few if any opinions or allegiances were changed, one way or the other, by the President's words.

Certainly, for example, the inclusion of a comprehensive government health insurance program is familiar administration doctrine which will be warmly supported by radicals in both parties, who have a hard time getting to the left of Truman on this point, and by Democratic party regulars, whose interest in the common people is sharpened with every glance at the calendar. Republicans generally favor a health bill on the states' aid principle, providing funds for care of indigents only. With the personal sponsorship of Senator Taft, such a bill will have all the benefits of prestige and precedence that a ship enjoys when the admiral is aboard.

Bernard M. Baruch, a doctor's son who made a million dollars before he was 30 years old and has

made an additional $29,000,000, or thereabouts, since that time, has proposed a health plan which is somewhere between the orthodox doctrines of the two parties and wears, as Baruch himself has expressed it, "the happy color of sensible compromise." Among other things, the Baruch plan would provide enrollment in voluntary health insurance programs for those who can afford it and participation in a compulsory government insurance plan for those who can't. As an authority on health insurance, Baruch's qualifications, which are mostly fiscal, might, in all logic, be questioned. The same question might easily be raised in connection with Truman and Taft, though the latter, alone among the sponsors of medico-political plans, has consistently asked for and received advice from representative groups among the professions concerned.

An overwhelming majority of the members of these professions believe that the Taft plan would provide the most help for those who need better medical care, with the least risk that money would be wasted or that political authority might supersede professional authority in the administration of benefits. Ruling out the suspicion that it is dictated by self interest alone, which in this case simply isn't warranted, the virtual unanimity of professional opinion should be a powerful influence toward passage of the Taft type of legislation.

Unvoiced opinions, however, influence nobody.

## Welcome, Doctor Hawley!

THE appointment of Dr. Paul R. Hawley as chief executive of the national organization of Blue Cross and medical service plans is a welcome step toward needed unification of the nation's voluntary prepayment health programs. As A.H.A. President Graham Davis declared at the announcement meeting, "In a common cause, these movements need to work together. Dr. Hawley will join in the problem of coordinating all our efforts to provide the very best in hospital and medical care to everybody in this great nation."

Dr. Hawley and his associates in Blue Cross and medical service plans face a difficult, complicated and exasperating task. To reconcile the myriad legal, technical and personal differences involved in building a uniform national prepayment plan will require the wisdom of Solomon, the patience of Job and an inexhaustible supply of sodium bicarbonate. Yet these differences must be resolved if we are to have voluntary prepayment on a scale which will effectively silence the advocates of government sponsored health insurance, without riding roughshod over the hospitals and doctors whose participation is the essence of the plans' effectiveness.

According to many people who have worked with him and observed him at work in the army and the Veterans Administration, Dr. Hawley brings to the new program a rare combination of broad vision and firm purpose. "The leaders of these two organizations have impressed me with their complete sincerity," he said in accepting the appointment. "They have fully convinced me that they are committed to providing a real public service. I would not have accepted the position on any other conditions."

If Dr. Hawley's leadership can inspire the nation's Blue Cross and medical service plan executives, hospital administrators and physicians to work devotedly together toward this common goal, regardless of whose income or influence is affected, or whose ox is gored, there is hope that the voluntary health movement may achieve its goal of a national prepayment plan.

## Autos or Autoclaves?

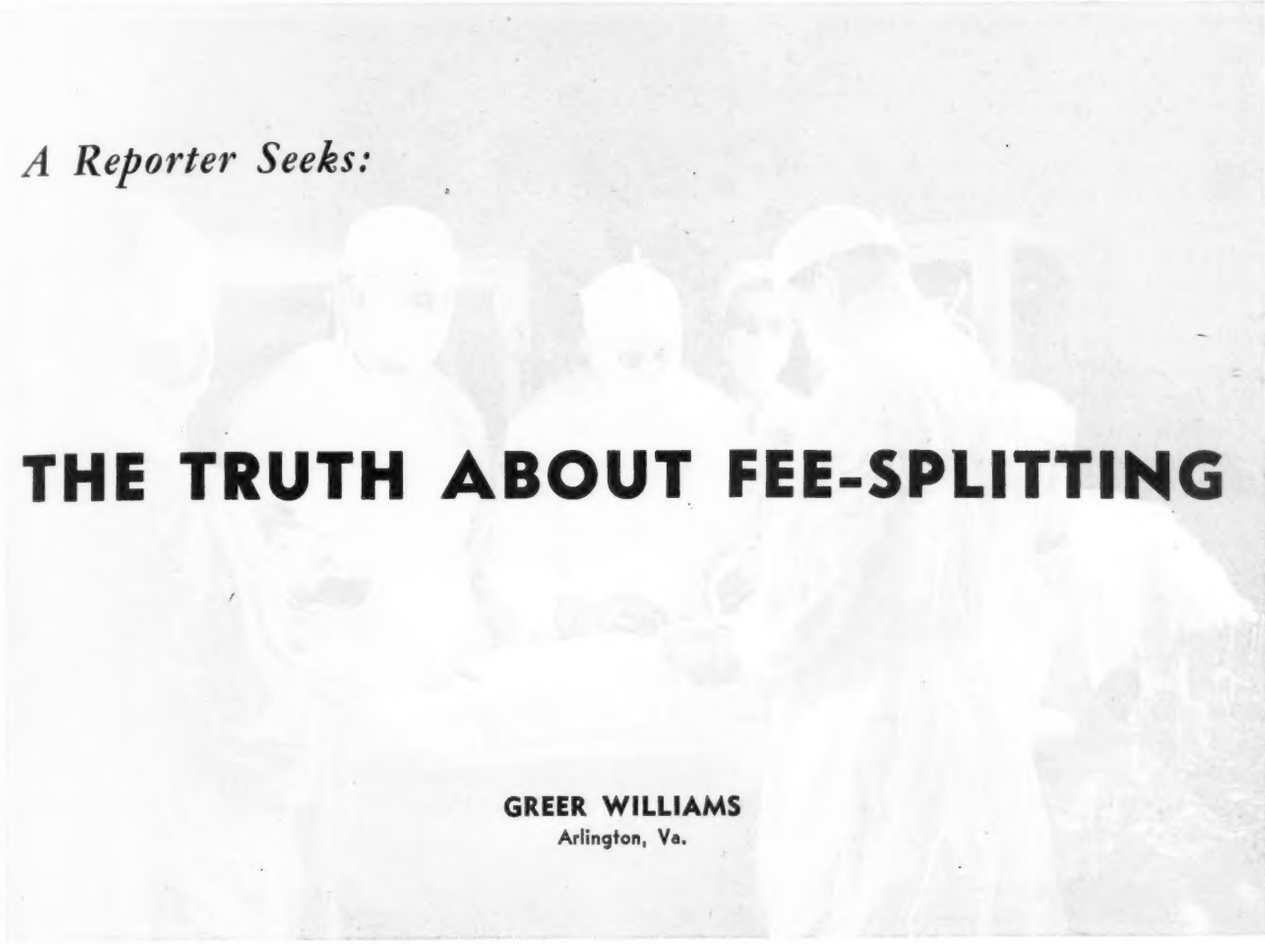
UNDER the proposed voluntary allocation plan for basic materials, industry-wide committees will review needs and then allocate available supplies according to priorities based on the general welfare. During the war, hospitals were next after army and navy needs in priority rating for most materials. In peace time, it is difficult to see how a conscientious committee could rank any other user ahead of hospitals from the standpoint of the public interest.

As discussions looking toward formation of the industry committee for steel were being held in Washington early last month, however, several manufacturers of hospital equipment were notified that their steel supply for the coming year would be reduced—by as much as 30 per cent, in some cases. At the same time, announcements from Detroit anticipated a substantial increase in automobile output for 1948, indicating that the industry will get more steel.

The need for an allocation plan is dramatically underlined by this prospect of more steel for automobiles and less for hospitals. Yet some steel company officials have expressed the opinion that effective allocation cannot be achieved without the urgent pressures created by war.

Here is a real test of the ability of our economy to withstand the ravages of peace. Individually and through their local, state and national associations, hospitals and hospital industries must make their needs known immediately to interested government and industrial authorities and to the public. It is doubtful that many people would choose cars ahead of hospital beds if all the facts were known.

*A Reporter Seeks:*



# THE TRUTH ABOUT FEE-SPLITTING

**GREER WILLIAMS**
Arlington, Va.

DOCTORS who liked obscurities used to call it dichotomy, but the secret division between the surgeon and the referring physician of the patient's payment for an appendectomy or any other operation is better known as fee-splitting. Beyond the term itself, however, the subject is quite a mystery. Doctors who do not split fees know little about it, those who do split do not talk about it, and the profession as a whole is embarrassed by it. Nevertheless, it happens.

The truth is that doctors believe fee-splitting to be a commonplace in many areas, medical ethics to the contrary. None of the 25 doctors I talked with confidentially denied its existence, and 21 had some awareness of it. These included several outstanding medical men whose names are withheld to save them from professional criticism for discussion with a layman of what traditionally has been a hot potato.

Fifteen believed fee-splitting to be widespread. Five admitted they split fees themselves. Even though all were promised anonymity, it took some courage for the latter to identify themselves as fee-splitters. They are in good standing in their medical societies, where it is no secret that fee-splitting is a breach of ethics punishable by expulsion. In 15 states, it is illegal and the doctor may be fined, jailed or lose his license to practice. Doctor X, a surgeon, said fee-splitting was quite prevalent in his city but it was too risky to talk about it.

While a few others also shied away from public discussion, the great majority of the 25 felt it was, indeed, high time to break the conspiracy of silence surrounding the subject. They accepted the challenge of the truth, well aware that the unsympathetic might give the facts a two-way stretch.

The commonest form of split described is as clear cut as a laparotomy. Doctor A, a general practitioner, makes a house call in the neighborhood and, after examining the patient, says, "I am afraid it's appendicitis. I'll get Doctor B to take care of you. I send him all my patients. He's the best surgeon I know." Doctor B performs the operation and all goes well.

Doctor A bills the patient for $5 or $10 and Doctor B sends him a bill for, let us say, $150. When he gets the money, he sends Doctor A a check for $75. He may, of course, prefer to make the transaction in cash. It is said to depend on how much the two doctors trust each other and whether they are willing to make a record of the split.

Doctor C and Doctor D said some general practitioners insist on doing the billing for the entire amount and then split with the surgical consultant. They told of two hard working surgeons who never charge more than $50 an operation but permit the referring physician to pay them and charge whatever the patient can pay. "I know a surgeon who is so good and commands such a big price," said Doctor E, "that other surgeons find they can make more money sending their own patients to him and taking a fifty-fifty split than by operating themselves." This classifies, however, as *rara avis.*

"Fee-splitting may be covered by some subterfuge," said Doctor F. "The

usual one is for the referring physician to scrub in and assist at the operation. His assistance may be limited to holding a retractor or an ether mask. There's nothing unethical about it if he sends you a separate bill for these services, but it's easier for him to collect from the surgeon as part of a joint bill." The value of a general practitioner as an assistant on a surgical team, suggested Doctor D, who had observed the same practice, is equivalent to that of a spectator joining in a professional football game.

Sometimes, continued Doctor F, the surgeon will pay the physician to come in and take the patient's blood pressure a couple of times following the operation—at $25 to $50 a visit.

### INCREDIBLE BUT TRUE

Such stories sound incredible, as they come to the layman from a profession with a well earned reputation for honesty and self sacrifice. This is part of the reason, it appears, why the problem is rarely publicized. To expose fee-splitting tends to reflect on a great many who are innocent of it. The rest of the reason is that facts are hard to get. But fee-splitting is a fact and has an explanation.

It seems to have gathered velocity around the turn of the century. At that time, thanks to bacteriology and the development of aseptic operating technic, surgery became far safer. It then began its rapid growth into a specialty beyond the ken of the family doctor. Many general practitioners, however, felt it unfair to turn their patients over to surgeons without reward. It was harder for them to collect a dollar than for the surgeons to collect a hundred. It was probable, too, that the next time a patient got sick he would head straight for the surgeon's office, and the family doctor was then out for good.

Many surgeons began offering commissions and some big-city doctors, medical history tells us, bid against one another to operate on the country doctor's patients. There were no controls except the individual surgeon's conscience. Whether the patient needed the operation and the surgeon was competent to perform it became confused, in some medical circles, with the questions of how much and how many. Doctors of high integrity were horrified.

Medical leaders denounced these conditions as scandalous, and the American Medical Association in 1903 put a paragraph in its code of ethics forbidding the "giving or receiving of commissions" as "destructive to public good and degrading to the profession." It was up to the state and county medical societies to discipline individual A.M.A. members, but their officials were practitioners and not policemen. Several states passed laws against fee-splitting. It is impossible to find one that used its law. Legal evidence was not easy to get. The patients never heard of the split, and any doctor making accusations on hearsay against even an obvious offender might be penalized as much as the accused. The guilty, it has been observed, are likely to be quick to file suit in retaliation.

The problem was to restrict surgery to the honest and the able. The American College of Surgeons was organized in 1913 for this expressed purpose. It condemned fee-splitting as "the buying and selling of patients" and required each fellow member to pledge, "Upon my honor as a gentleman, I hereby declare that I will not practice the division of fees."

Today, the American College of Surgeons continues to exact the no-split pledge from its 15,000 or more fellows. The A.C.S. imposes the same requirement on the staffs of its 3100 inspected and approved hospitals, whether all the staff doctors are F.A.C.S. or not. Surgeons are warned to make their charges entirely separate from the referring physician's, avoiding joint or combined bills. Hospitals where fee-splitting is "known to exist" are disapproved; the college's manual of hospital standardization emphasizes that "The evils of fee-splitting are well known to the medical profession and to hospitals."

A college official at Chicago headquarters said the organization investigates charges of fee-splitting, tries to get hospitals to bear down on the wayward and cooperates in community cleanups. A few fee-splitters have been ousted from A.C.S., he said, but many more fellows have resigned to escape formal investigation. Reformed fee-splitters, he indicated, may be accepted for membership.

This official conceded that fee-splitting still exists in "individual communities" and "individual hospitals," but said, "There has been a great improvement." He added that today's fee-splitting is of a more benign form.

An American Medical Association official, granting that "some is inevitable," took the same view. They are probably correct. Doctor G, a fee-splitting surgeon whose problem will be presented, maintained that it is possible to be honest in the treatment of patients while committing the "technically dishonest" act of secretly splitting their fees.

### FIND NO DOWNWARD TREND

Not all medical authorities agree with the official point of view. Some claim that there is no downward trend in the prevalence of fee-splitting. They generally recognize, of course, the improvement in the competency of the average surgeon. In contrast to horse-and-buggy days, the A.C.S. and A.M.A. have set high standards for the training and performance of surgeons in approved hospitals, and the American Board of Surgery goes still further in its qualifying examinations. In short, fee-splitting surgeons now are likely to be better trained and supervised and therefore less of a menace.

But, said Doctor H, the director of a medical foundation, "Fee-splitting is just as prevalent today as it was 20 years ago." The favorite phrase among doctors that I interviewed was "quite prevalent." There are no surveys or statistics on fee-splitting, owing to

Greer Williams

**Greer Williams has been a reporter and writer on science subjects for twenty years. His career as a newspaperman began in Detroit, then shifted to Chicago, where he was on the staff of the *Tribune* for several years before becoming science editor of the *Sun*. After a three year term with the army, which he entered as a private in the ski troops and left as a captain in the air forces, Mr. Williams became a public relations consultant for the Veterans Administration Department of Medicine and Surgery. He has also served in the same capacity for a number of medical associations and clinics and has written extensively on medical subjects for the *Saturday Evening Post* and other magazines.**

**In making this investigation of fee-splitting, Mr. Williams visited half a dozen cities, talked to many physicians, surgeons and hospital authorities. "The undertaking can hardly be called an investigation, in the legal sense, or a survey, in the scientific sense," he says. "The method was reportorial and so are the findings. It may be argued, however, that if a physician may diagnose acute appendicitis from its signs and symptoms, so may a reporter estimate the truth by evaluating the symptoms of it."**

the little matter of secrecy, no doubt. It would be desirable to have a survey, on an anonymous basis, of course. Otherwise, the percentage who split in any locality could not be proved without an audit of every doctor's accounts and records. It was possible, however, to get all kinds of opinions.

"Ninety per cent of the general practitioners in this city want a split," said Doctor I. Doctor J, of the same city, put it at more than 75 per cent and charged that perhaps an equal proportion of the local surgical group would give a split. Three out of four was also the estimate of Doctor F in a second city. In a third city, I heard opinions from 50 to 75 per cent for different hospitals, but Doctor K claimed it would run to 90, or possibly 95, among his fellow surgeons in that city. He could only think of six hospitals out of the hundred or so in the area where fee-splitting did not exist to some extent. In Doctor J's city, he and others knew of only two among approximately 30 hospitals where the staff did not split fees.

### THEY ARE NOT WILD GUESSES

These were guesses, but they were not made by wild men. Doctor K, who said he splits only when the family doctor insists on collecting the bill, and Doctor J, who said he never splits, are highly active and well informed. Both are certified as diplomates of the American Board of Surgery, placing them among the top 2900 of their specialty.

It may be that fee-splitters would overestimate their prevalence and nonsplitters underestimate the problem. If it were only from 35 to 50 per cent, or about half of the percentages named, it would still be a major paradox of principle *versus* practice.

In 1944, the president of the New York State Medical Society said that fee-splitting in New York City was "quite a serious evil." He was testifying in the Moreland Commission's investigation of workmen's compensation graft, but his statement was not limited to this aspect. The commission's report to Governor Dewey pointed out that the county medical societies had the responsibility for appointing workmen's compensation physicians and for looking into misconduct. It said:

"Kickbacks ranging from 15 to 50 per cent were paid . . . to more than 3000 physicians in New York, Kings, Bronx and Queens counties alone. . . . The medical societies of those counties have seemingly closed their eyes to this widespread system. Indeed, it was proved that these kickbacks were common in private as well as in compensation cases. They constitute a secret and illegal tax."

Testimony showed that referring physicians demanded kickbacks from everybody — surgeons, x-ray laboratories, surgical appliance companies, opticians and even specimen analysis laboratories.

### IT'S AGAINST THE LAW

Fee-splitting on workmen's compensation, ironically enough, was already prohibited by law. So the New York State legislature amended the medical license act to make it illegal for any and all doctors to split. Two years later, Doctor L informed me of a group of general practitioners in New York that, he said, had openly advocated fee-splitting.

The doctors to whom I talked were in general agreement on the habits of fee-splitters. As Doctor C, who had observed the situation in four cities, put it: "Fee-splitting is worse among younger than older doctors, among the poor than the wealthy, among the less competent than the more competent, outside of medical schools and their teaching hospitals than in them, in the South than in the North, in the West and Midwest than in the East."

In all cases, there were exceptions. For instance, there are midwestern and southern communities where the doctors never thought of splitting a fee. Many a specialist from a medical school never sees a split, but it is not unknown to all medical faculties. The narrower specialties, such as orthopedic surgery or brain surgery, don't feel the pressure for kickbacks. Rather, the doctors said that general surgery, with its great volume of both patients and fees, offers the biggest opportunity for a split, usually with a general practitioner.

It is apparently not common for an internist to seek a split from a surgon. Such a specialist can make from $25 to $35 for a comprehensive examination. There are equally thorough and upstanding general practitioners who wouldn't touch a split, although their fees may be much less. As the result of medical specialization and the technological refinements of medical care, however, many general practitioners are pictured as being left out on the economic limb. Some, critics have charged, become medical brokers.

Examining the problem in the best possible light, some fee-splitters argue that the only thing wrong with the practice, in its modern form, is to be found out. A business man entering the discussion might ask what is so bad about splitting the fee anyway? Commissions, rebates, discounts or other inducements are an accepted practice in American business. It's a way of bringing in the customers and doesn't change the quality of the goods or service. That is so. But when it's soap or real estate, to buy or not to buy is the customer's responsibility. When it's an operation involving the patient's health or life, the doctor decides for him. It is a trust. The patient does not want any possibility of the decision to operate or the choice of the surgeon to do it influenced by a deal. The point that the physician assumes fiduciary responsibility is the basis for his professional pride. He can be trusted.

Actually, as an outstanding authority on organized medicine correctly stated the question, the only thing wrong with fee-splitting is to keep it a secret. It is a deception of the patient but would cease to be so if the doctors informed the patient or his family of the terms of their transaction.

### WHY NOT CHANGE THE RULE?

This suggests the simple solution proposed by Doctors G and M, both fee-splitters. "Why not," they asked, "change the ethics? The ethics are fine but they don't work. Make it legitimate to give or receive a commission for a referral. Set up a fixed schedule of prices."

The reasoning of these two young men, a surgeon and a general practitioner, is that the system of medical practice is stacked against the newcomer. The physician trains for eight years; the surgeon, for eleven, to meet bare requirements. They represent an educational investment of from $10,000 to $20,000, of their own, their family's or, in some cases, the government's money. They earn little beyond board and room as interns and residents, and they are 28 or 29 years old before they are ready to earn a living. Like everyone else, they have the problems of parents, wives, children and the desire to do right by them. They feel overeducated, under-

privileged and hungry for money.

"I hang up my shingle," said Doctor M, "and collect a $3 fee here and $5 there on night calls and cases other doctors won't touch. It doesn't pay the rent. Then I get a patient with what looks like an operable tumor. She needs a hospital work-up. I'm on a courtesy staff, but that doesn't mean a thing. I can't get a bed for two months. I have no doctor father or uncle or big following of patients to get me on an attending staff. So I send the lady to a well known surgeon and never see her again. Later I hear the surgeon took her tumor for $500 and she is doing nicely.

### NOW HE'S SMART

"But I'm not. They don't teach you these things in medical school, but now I'm smart. I don't let any big shot surgeon take my cases away from me without getting paid. I'm also doing some surgery in a small hospital. No, it's not approved, and it's not so good. But the young fellows who work there can't get on the staffs of the big closed hospitals. The best surgeon in town won't split, so when I get a complicated case I send it to Mayo Clinic, which doesn't split fees either but always sends the patient back to me with a complete record of what was done. They're still my patients."

Meanwhile Doctor G is having trouble getting started in the surgical end of the business. "Just where," he demanded, "does a trained but unknown young surgeon get his cases? If he's lucky, he gets a job assisting an older surgeon with a closed practice, doing his charity cases for him and occasionally one of his private patients. But me, I'm so desperate when I start practice that I'd gladly pay someone for the privilege of operating on him to keep my hand in.

"So I do a little general practice on the side to earn some money and find a couple of young physicians who will send me surgery if I split with them. Now I want to work for my American Board examination and do enough cases to qualify for the American College of Surgeons, but I'm between two fires. The board says I must devote 100 per cent of my practice to surgery and the college says I must not split fees to get cases. The system says *I'm* wrong, I say *it's* wrong, and if we can't change the system, change the ethics."

Doctor K corroborated the young surgeon's complaint. The A.C.S. no-split pledge, he said, can drive the surgical beginner into general practice for income and a source of surgical cases, while the board's 100 per cent surgery rule drives him into fee-splitting.

Doctor G's argument for a change in the ethics is not new. The issue has been hotly debated in medical circles for years. Critics of the ethics say that fee-splitting is no worse than reciprocity anyway, and reciprocity—"send me a patient and I'll send you one"—is as much a part of medical practice as the caduceus. A New York County Medical Society committee weighed the question some years ago and decided that ethical fee-splitting would not remove the incentive to split in secret.

Some surgeons would still offer bonuses, or double splits. "Unscrupulous specialists would gouge the public simply by adding that amount to their charges," the committee stated. "If the general practitioner is in general underpaid, it is because the public has not been educated to a true estimate of the value of his services. Such an education must come from the profession." The society reaffirmed its opposition to fee-splitting.

This corresponds to a part of the American College of Surgeons fellowship pledge requiring the surgeon "to teach the patient his financial duty to the physician." As for the simpler alternative of the split, the A.C.S. advises, "The most effective way of abolishing it is through the intelligent cooperation of the medical profession, the hospitals and the public, and especially, education of the public as to its evils."

It may be impertinent to ask when public education is to begin. Few of the laymen to whom I've mentioned fee-splitting had even heard of it. One pronounced it "incredible." Medical leaders do not speak out, explained one surgeon who is outspoken, because of the stigma on their profession. He asserts that fee-splitting would cease to be a problem if it were ethical and open. Then anybody could split and everybody could talk about it and the public would learn from the better doctors what to demand from the lesser ones.

"The way to stop fee-splitting is to cut all standard surgical fees in half," said Doctor K. "That would do it." His statement was perhaps rhetorical, but his contention that "I can make all the money I want at $75 top, even if I don't hit $50,000 a year," raises a point occurring to many a patient when he gets the surgeon's bill. As an observer of human nature, the patient may find it difficult to separate a fee of several hundred dollars from a suspicion that his personal misfortune is being exploited. The possibility of a split, if he knew about it, would scarcely allay his doubt, and the necessity of keeping it secret would seem to prove the point.

The split habit may start as an economic drive for the young doctor, but some of the doctors concede that it doesn't stop there. It continues, as Doctor J observed, until the older surgeon is so well known that he no longer need split fees to maintain a big practice. Then he may reform.

Doctors often say that it is hard to make a good living in private practice. On the other hand, they belong to one of the highest paid professions in the country, even topping lawyers. In 1943, a survey by *Medical Economics* showed that 84 per cent of physicians grossed $5500 or more a year. The average gross for a general practitioner was $10,747 and for a full time specialist, $15,837. Young Doctor G, who said splits accounted for only 5 per cent, placed the net income for his third year of surgical practice at $20,000. Young Doctor M, who attributed 30 per cent of his general practice income to splits, supported his family and in three years paid for a home and a private clinic, together worth around $25,000 (before inflation).

### THEY STILL DON'T LIKE IT

Whatever their financial status, most fee-splitters dislike the system. Some challenge the medical observation that fee-splitting leads to incompetent surgery, unneeded operations and overcharging. But none maintains it is fair to deceive the patient.

Medical observers have debated a number of possibilities for solving the problem beyond making fee-splitting ethical or making a public attack on the unethical. One is group medicine. Young doctors can form a clinic, attract patients with prepaid plans or low cash fees, share expenses, divide the income and give better service—if, as Doctor J said, they and their wives can get along with one another. That is a problem, too. But many a county medical society has bucked such clinics as unfair competition and young medicoes seldom find group medicine an attractive prospect in medically-

starved, low-income areas. Wealth is centered in big cities and so are doctors and hospitals. That's where most young doctors go.

Others advocate giving interns and residents salaries providing real security and then, when they go into practice for themselves, saving them from temptation with basic salaries, fellowships or subsidies for doing part time free medical care, research or public health work that will hold their interest. Stimulation to pursue a scientific career as a cultural, rather than commercial, way of life is of profound importance, according to Doctor J.

### IT COMES BACK TO UNCLE SAM

On the other hand, hospitals don't have money or places for more than a few youngsters, and some medical oldsters get a fixed look and begin salivating when they hear such talk. The only party with enough cash to remedy the whole problem of maldistribution of medical service and its internal stresses is Uncle Sam, they well know, and that means government financing which means government control which means bureaucracy and politics which means God help us. Still, one intelligent conservative after another says that he dislikes the present system, which requires a staff doctor to work for nothing on the hospital's charity ward or in its free clinic and meanwhile to support himself from a half time office practice and a few high pay private patients.

Doctor H, the foundation director, raises the broad question of professional attitude and morality. The medical profession, he believes, has admitted too many individuals whose self interest is stronger than their consciences, thus reversing the professional dictum that financial reward is secondary to humanitarian service.

"The incentive to split fees," he said, "will continue to exist as long as the medical schools make no better selection of students for moral character than they do now, as long as specialization requires general practitioners to refer patients to specialists who can set much higher fees, and as long as the medical profession is disinclined, as at present, to discipline its members."

One group that has refused to wait for this medical millenium is the Columbus Surgical Society. It is the only professional organization of which I've heard that is making a frontal attack on fee-splitting. This article is the first published report on it.

Two years ago, not only was Columbus the capital of Ohio, the campus of Ohio State University Medical School and the home of 400,000 persons; it was also, Doctor N informed me, one of the nation's most split-happy communities. Then, on Jan. 1, 1946, fee-splitting was almost entirely stopped, overnight.

"We weren't all fee-splitters, don't misunderstand me," said Doctor N, an interested surgeon and close observer. "But things were pretty bad. For example, one general practitioner refused to go on a night call, directing the patient to a hospital emergency ward instead. The resident called in a surgeon and the general practitioner demanded a 50 per cent split, just for answering his telephone. Another physician walked through a hospital and saw the relative of one of his own patients on the ward. He got hold of the surgeon and insisted on a split."

In contrast, said Doctor N, there were many conscientious doctors in Columbus who hated this commercialism. Two of them, both surgeons, hit on an answer after two years of figuring and planning. What they did was organize the Columbus Surgical Society—much like any other professional society in its scientific and educational purposes except for one thing. Each member was required to sign not only the American College of Surgeons' no-split pledge but also an agreement to submit his office records and accounts and even his income tax returns to an annual audit to determine whether he lived up to his word. Submitting a copy of one's income tax return seemed like drastic business, but each member signed a waiver to permit it. The by-laws provided that the society would hire a certified public accountant to make the audit and report any evidence of fee-splitting to the group.

Why, it may be asked, should a fee-splitting surgeon want to join a tough outfit like that? The founding surgeons gave him a pressing reason. From each hospital's board of trustees they obtained an agreement that only society members could hold positions on the surgical staffs. This, of course, concentrated a vast potential of power to regulate in a voluntary organization, since its by-laws stated, "The society shall be the sole judge of the qualifications of its members." Nevertheless, approximately 97 per cent of the city's surgeons accepted membership. Only about 10 per cent, according to Doctor N, needed any real pressure to bring them in.

But what, the cynic might now ask, would prevent a surgeon from joining and then keeping no records of his kickbacks or, as an alternative, letting the referring physician collect the money and split in cash? Well, for one thing, explained Doctor N, anyone can count a surgeon's operations; the hospitals schedule and record each one. If he hasn't put out his own bill on each one, he can explain why. For another thing, doctors tend to know each other's business methods in a city the size of Columbus. Moreover, a patient will talk to anyone about his operation—and how much it cost him.

The surgeon who collected a bill and split it, said Doctor N, would have to show it in his income tax return—all as gross income—and then deduct half as business expense. To hide the split, he would have to declare as net income the half he gave to the referring physician as well as his own half. In that case, his expenses plus the tax on 100 per cent would eat up the 50 per cent he kept.

### MERELY GUILTY OF TAX EVASION

Of course, if the surgeon wished to conceal his split income by leaving it out of the return, he then would merely be guilty of income tax evasion. The Collector of Internal Revenue is inclined to regard this as a penitentiary matter, so it did not appear to be a particularly good way of avoiding the society's fee-splitting hook. In brief, the lions of medical ethics had no teeth, but the man with the whiskers has. The Columbus Surgical Society merely borrowed the use of them.

It was not surprising, when the lid went on two years ago, that certain Columbus general practitioners were said to be calling all over town for a split and finding none. Soon they were wryly calling it the "Purity League." The results of the move were spectacular, if somewhat mixed in their implications.

The total number of operations performed in Columbus hospitals immediately dropped, said Doctor N, owing to a reduction in the unnecessary ones. There was much less overcharging by the surgeons, he said, to make up for the split. A few of the reformed surgeons whose practices had been built on fee-splitting ended the first year of the revolution in the red. Most could afford it, however, and Doctor

N paid tribute to them as strong supporters of the "Purity League." Frankly, one told him, he enjoyed the feeling of honesty.

Doctor N's first impression was that the more wayward general practitioners were giving their patients more and better service so they would not be ashamed to charge more. After nearly two years of observation, he reported, "Unfortunately, there has been an unexpected reaction along this line. Whereas previously we had been virtually forced to do some surgery we thought was unnecessary, we now find that the general practitioner has been treating acute surgical emergencies for too long a period of time. We are now seeing too many cases of ruptured appendix. Some of the unprincipled practitioners have spent too much time in so-called preparation of the patient before surgery as a means of building up their fee. This is becoming less, however, because the general practitioners are now feeling the weight of public reaction. I think the trend is back to a sounder basis."

Doctor N also stated that general practitioners began demanding that they be permitted to assist in surgery. Their lack of training, he said, made them a nuisance and a hazard to the surgical team, but "Here, again, the public has become aware of the excessive fee charge for assisting in surgery."

"One of our greatest disappointments," said Doctor N, "has been the lack of support given by some hospitals, which have seemed much more interested in retaining doctors on their staff than they have in cleaning up the profession.

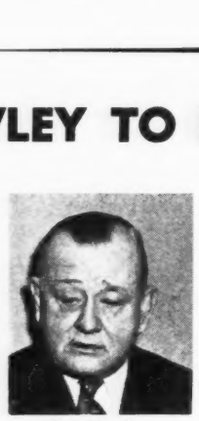
"One of our greatest and pleasantest surprises has been the backing given us by the Internal Revenue Department. It must be clearly stated that the Internal Revenue Department did not give us backing because it approved the principles of the society, but because several of the would-be fee-splitters feared our audit and for that reason were hiding their incomes, as were also the G.P.'s to whom the split was paid."

Following the policy of leaving suspected fee-splitters to the last, the society's accountant, in his first audit, found 99 out of 104 clear of suspicion. The others, at this writing, apparently remained to be examined. It is the intention of the society, said Doctor N, to accumulate data and to seek prosecution of both the surgeon and the general practitioner. Both are equally an offender under Ohio's ancient no-split law, which provides for revocation of the fee-splitter's license to practice.

Doctor N asked that his name be withheld because "the proponents of the plan have been persecuted to a considerable degree already." Such seems to be the price of moral indignation.

Whether or not the method of the Columbus Surgical Society is sound, the leaders' courage in facing the issue of fee-splitting and trying to do something about it is undeniably admirable. Its aim, to quote an old medical chestnut, is "in the best interests of the patient."

# HAWLEY TO HEAD ALL PREPAYMENT PLANS


Dr. Hawley

WASHINGTON, D. C.—Dr. Paul R. Hawley, who resigned last month as chief of the department of medicine and surgery of the Veterans Administration, has accepted an appointment as director of a new national organization formed jointly by the Blue Cross Commission and Associated Medical Care Plans, Inc., the national coordinating agency for prepayment medical plans. Dr. Hawley will take office April 1, according to the announcement made at a dinner in his honor here January 10.

Headquarters for the newly established Blue Cross-medical plan organization will be established in Chicago, where both commissions now maintain separate offices.

In accepting the appointment, Dr. Hawley asserted his conviction that prepaid health service can be administered most effectively by a voluntary system. "I have been told by so-called experts that privately operated prepaid health service can never be successful," he declared. "This I do not believe. I have further been told that this undertaking is too gigantic for a private, voluntary agency, and that only the government is in a position to make it successful. I would have no quarrel with this point of view except that it is invariably coupled with the provision that, to make it successful, the government would have to control medical practice. Nor would I object to government control of medicine if this would elevate the standards of medical practice in this country. But I have seen government medicine in operation in other countries, and I know what government control does to medicine. I want no part of it for our people."

Outlining the task that the new prepayment organization faces under Dr. Hawley, Roy E. Larsen, president of Time, Inc., who presided at the announcement meeting of the two commissions, said: "The time has come when the 150 different hospital and medical plans must be coordinated to represent a single, national, voluntary health movement. Certain conflicts of interest in the two fields must be overcome to this end. Individual community plans must always be geared to local needs and conditions. However, a unity and coordination between plans must be achieved and a national organization established which can provide nationwide business with a more uniform and widespread coverage than is available at present."

Among the seventy-five national hospital and medical leaders who attended the meeting, Graham L. Davis, president of the American Hospital Association, welcomed the appointment of Dr. Hawley on behalf of the nation's hospitals and hospitalization plans, and Dr. Edward L. Bortz of Philadelphia, American Medical Association president, assured Dr. Hawley that the organization would receive every assistance from the A.M.A.

A native of Indiana and a graduate of the University of Cincinnati Medical School, Dr. Hawley was a regimental surgeon in France during World War I and, as a major general, headed all army medical department operations in the European Theater during World War II.

## THE ARMY'S NEW TRIPLER—

# MONUMENT TO MEDICAL SCIENCE

**LT. COL. JAMES T. McGIBONY, M.C.**
Tripler General Hospital, Honolulu, T.H.

SCHEDULED for early completion, the army's new Tripler General Hospital on the Island of Oahu in the Territory of Hawaii is located five miles from downtown Honolulu. The new hospital will replace the wood buildings located midway which have furnished general hospital treatment for the army for almost half a century.

Construction of the new hospital was initiated during June 1944 but owing to other higher priorities for labor and materials progress was slow during the early period. Since V-J Day concentrated efforts have resulted in construction work moving ahead at a rapid rate.

The new Tripler General Hospital is located on the rugged terrain of the lower westerly slopes of the Koolau Mountain Range, with a beautiful, unbroken view of the Pacific Ocean in a 180 degree arc. The entire site will occupy approximately 365 acres of land as it will be a self contained post with all the necessary post service facilities, as well as the main hospital building. Taking full advantage of the natural factors present, the magnificent view of Oahu's southern coastline and the prevailing cool mountain winds, the architects have included in the design of the hospital generous lanais, informal grouping of buildings and irregular plans to create a restful atmosphere for patients and avoid any institutional environment. Located on a ridge flanked by steep ravines, the site has a rise of 700 feet in 1¼ miles. The main hospital building occupies the largest level area with other buildings arranged conveniently about it as shown in the site plan.

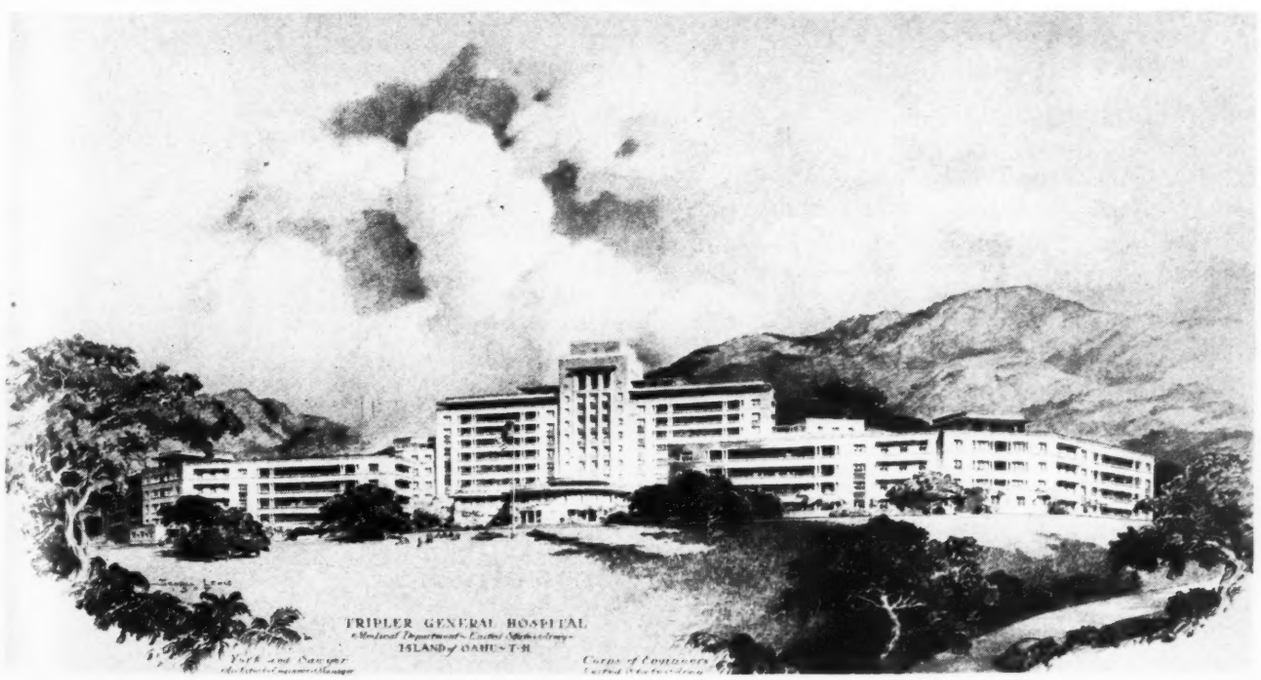
In keeping with the architects' efforts to maintain an easy, informal atmosphere, the treatment of exterior surfaces of the main hospital building called for the use of stucco in a warm rose coral color.

The wings of the main hospital group are oriented to receive maximum benefit from sunlight and prevailing winds while protected lanais on the lee sides of wards furnish unobstructed views of the Pacific. Ambulatory patients can utilize roof decks which have been provided with protective coverings. Horizontal projecting canopies of reinforced concrete over the windows serve as protection from the sun's glare and from rain.

The buildings, made of reinforced concrete rigid construction with stuccoed concrete block walls and partitions, are designed to be earthquake resistant by certain features in design and construction, including tied foundations and the division of the buildings into structurally isolated units.

When completed, the new Tripler General Hospital will have a capacity of 1500 beds; it was planned not only to take care of the military needs but also to provide up to 500 beds for the Veterans Administration and 100 for the United States Public Health Service when needed. At the present time some beds are provided

ARTIST'S DRAWING OF THE NEW TRIPLER GENERAL HOSPITAL



for the V.A. at old Tripler but that agency also has to seek beds elsewhere in overcrowded hospitals of the Territory. Upon the completion of new Tripler these patients can be concentrated in one hospital near Honolulu.

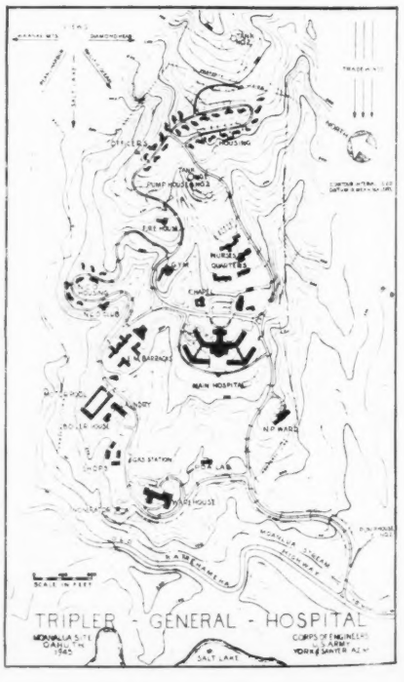
The task of landscaping the hospital site is tremendous. Its more nearly level areas having been used primarily for pineapple cultivation, the site at present is quite barren in spite of considerable rain swept in by mountain winds. However, landscape architects, looking many years into the future, envisage the hospital grounds as a great garden containing a collection of tropical trees and shrubs unrivaled in any botanical collection in the area. Under the direction of the architect-engineer, the services of a local landscape architect, Robert Thompson, are being utilized for preparation of the master plan for landscaping.

#### AID TO OCCUPATIONAL THERAPY

In keeping with the overall plan of the hospital which integrates functional design with an attempt to create the pleasant atmosphere of a modern residential community, the landscaping pattern has been designed to assist in the actual operation of the hospital as well as to beautify the surrounding grounds. For example, considerable thought has been given to aiding the occupational therapy program by including groups of local fruit and nut bearing trees whose crops can be harvested with the help of patients.

The architects for new Tripler are York & Sawyer of New York, with the office of the army chief of engineers in charge of its design and construction. Representing the Western Ocean Division is the District Engineer, Col. B. M. Harloe, who recently succeeded Col. B. L. Robinson. Prime contractors for the job are Morrison-Knudsen, Inc., and Peter Kiewit Sons, Inc., of California. The work was planned in close cooperation with the office of the surgeon general of the army who by calling upon his staff and wartime consultants incorporated latest developments in hospital treatment of army personnel. The directors of the various departments in the office of the surgeon general approved the design of each special clinic and department before it was accepted.

The typical standard ward or nursing unit contains 44 beds, 32 of which are in a large open ward consisting of four Copenhagen bays, with the remainder in smaller units. The partitions between beds in the Copenhagen bays are so designed as to provide ample space for slippers, towel, bathrobe and small personal articles of individual patients. On the panel back of each bed are found the electrical outlets for bedside light, nurse's call and radio receiver with five channel selectivity. All patients have access to the sheltered lanai where they may take advantage of the magnificent views. At the end of each ward there is a large day room which serves normally for recreation but can be used



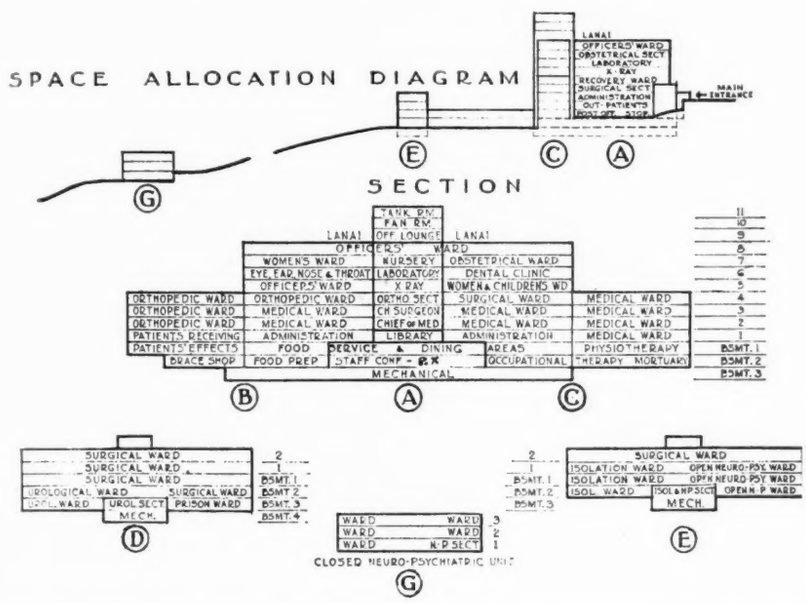

**Top: A view of one of the buildings in which nurses are to be housed. Center: The closed neuropsychiatric section is an individual unit with separate facilities for recreation, occupational and physical therapy and feeding of patients: Right: Site plan of the entire hospital.**

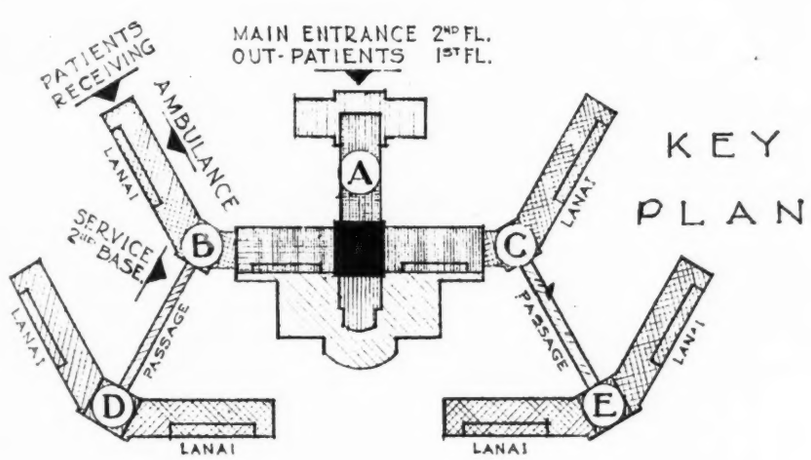
for immediate expansion of the hospital in case of emergency.

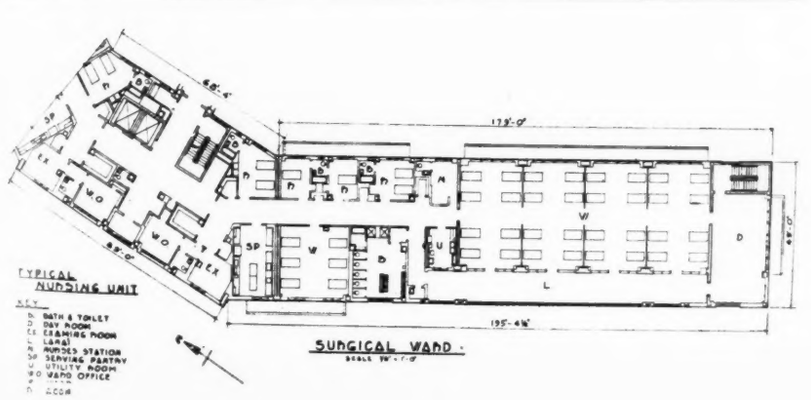
For the first time the army has installed in one of its hospitals the pneumatic tube system found in many of the large civilian hospitals. Its installation was based upon data accumulated in other large army hospitals indicating the need for such a system, as well as upon favorable reports from civilian hospitals that had pneumatic tubes in use. It is expected that this system will reduce personnel requirements and also expedite final patient disposition, which is always a problem in army hospitals.

Because advantage has been taken of the natural slope of the site, the administrative, patient and service traffic has all been segregated on different levels and areas in an effort to eliminate crossing and confusion in traffic corridors. All clinics, the operating pavilion, recovery section, special departments and approximately 90 per cent of the nursing units are dead-ended to prevent needless traffic through them.

**Top: Space allocation diagram, with areas labeled according to respective function. Center: Diagrammatic plan of the main hospital building showing the central administrative unit "A" flanked by wings joined to the central mass by connecting corridors. Bottom: Typical nursing unit showing bed arrangement.**




## SEPARATE N.P. UNIT

The neuropsychiatric section for closed ward treatment will be housed in an individual unit where separate indoor and outdoor recreational facilities, occupational therapy, physical therapy and feeding facilities will be provided in pleasant surroundings. Expansion facilities for handling closed ward patients are possible on certain wards in the main hospital group by the installation of special screens as the doors leading to the lanais of these particular wards were purposely omitted.

Adequate facilities for physical therapy, occupational therapy, orthopedic brace shop, staff conference rooms and amphitheaters for teaching purposes have been provided as have the clinics necessary for hospital operation. In addition to personnel housing, the hospital will have its own recreational facilities, utility shops, warehouse and commissary, laundry, chapel, motor pool and post exchange. Construction of the Pacific Ocean area laboratory shown on the site plan has been deferred. It was the original plan that this laboratory would serve the entire Pacific Ocean area as the hospital itself has its own laboratory. There is a central laboratory housed in temporary buildings on Oahu at the present time rendering valuable service to the surrounding area.

With necessary equipment already arriving, completion of the new hospital will be followed by a transfer of activities from old Tripler to a new home—a monument to medical and engineering science and a guardian not only to the military personnel but to the entire community in times of crisis.

# *Purchasing* MADE EASIER

**CHARLES E. DUNCAN**
General Storekeeper, Miami Valley Hospital, Dayton, Ohio

PURCHASING, in one form or another, is something that no institution can do without; no matter what its size, it has to buy something sometime.

The purchasing agent or buyer of institutional supplies nowadays must exercise all the ingenuity and resourcefulness at his command; he may even have to dig up a little more of each in an effort to acquire the goods he wants, within a reasonable time and at prices he can afford to pay. Dealers will accept orders for almost anything and in any quantity, seldom, if ever, saying when, if ever, the goods will be shipped. Often when they finally are received the price is far above the price in effect when the goods were ordered. Is it any wonder the poor buyer may harbor thoughts of a homicidal nature?

No one has yet thought up an effective method for overcoming the difficulties plaguing the field in its effort to obtain the supplies and equipment it so sorely needs at prices it can pay. The purchasing agent can, however, help the situation along in his own private little world—the purchasing department—by taking stock of himself and remembering the Golden Rule he should have learned years ago in school—"Do unto others as you would have others do unto you."

## COURTESY WORKS WONDERS

When a salesman calls on you, receive and treat him courteously; listen to his "line" with all the patience and interest you can muster. Give him your entire attention; sometimes he can give you some valuable information. Salesmen are only human and naturally have some customers whom they like better than others. A salesman can help a great deal in obtaining the goods you need. This does not mean you have to wine and dine him; reputable firms do not employ such salesmen. A full share of common courtesy will work wonders at times.

Another way a buyer can help himself is to watch the markets specializing in his particular line of commodities. By so doing he can anticipate price increases or impending shortages and take the necessary steps to guard against them.

Checking up on the letters he writes and his conversational ability will help a buyer obtain the goods he seeks. A buyer may get so angry at a firm for a usually (though not always) seemingly intentional wrong done him that his anger impels him to write a most unpleasant letter to the firm. Well, that's all right; go ahead, tell them where to get off. Make your letter red hot—use asbestos paper if necessary. Go on, get it out of your system. Read your letter over carefully. Feel better? All right! Now tear it up—into very small pieces and file it in the wastebasket.

Now write a nice friendly business letter remembering that this firm may have troubles, too. Such a letter will get results that a harshly worded one never will. Abraham Lincoln used this method, or so I read in a book.

The same thing applies to conversations. Go off somewhere and talk to yourself, if you must, but never vent your anger on the person you think wronged you until you have heard his story; then let your conscience be your guide.

A person unversed in the art of institutional buying may think that purchasing the supplies and equipment needed is a simple matter of telling a salesman what he wants or ordering from a catalog. But actually it is not so simple. The buyer must know why he is buying a particular item, what it is used for and how it is to be used. He must know the specifications, the proper quantity to buy so that the stock will be evenly balanced at all times—not too much and not too little. He must know the price to pay and be able to select the most reliable firm from which to buy.

The purchasing procedure can be simplified to a great extent by standardizing, insofar as possible, the equipment used throughout the institution. A hospital that purchases several makes of suction machines, for instance, that are all used for the same purpose sometimes presents the buyer with a difficult problem in obtaining replacement parts for them. Whereas, if only one make of machine were used the buyer would immediately know where to get parts. He might even stock the parts that most frequently need replacement.

Good inventory records or perpetual inventory records are another example of simplifying the job of replacing stock or inventoried items. These records will give the buyer the necessary information regarding the item, such as where it was previously purchased, how much was paid for it, how much time elapsed between ordering and receiving it, how fast it is being used, its specifications and so on.

The degree of simplicity accomplished in the purchasing department itself helps to lighten its burden. This department must keep certain pertinent records which contribute to its successful operation. It must not be hampered by the task of keeping useless records that mean nothing.

## CENTRALIZED OR DECENTRALIZED?

An institution will always be better off if one person does its purchasing, the principal reason being the economies realized through greater buying power.

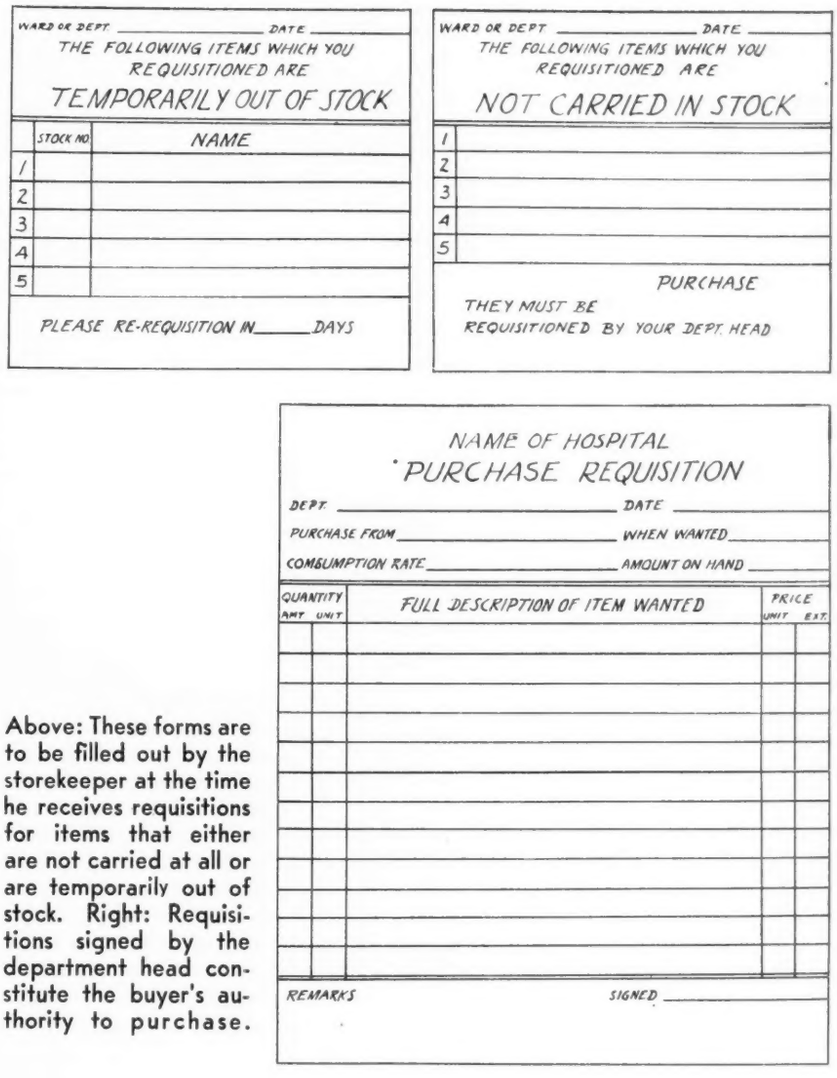
Inventoried items that are stocked in the storeroom are, for the most part, goods that are used throughout the institution. Therefore, when one person buys all these goods he can get enough to supply the whole institution at one time and can save money on quantity purchases.

In decentralized purchasing each department would buy its own supplies

—usually a little of this and a little of that—seldom enough to benefit by a purchase discount. On the other hand, I have known department heads who knew nothing about purchasing (but thought they did) to order enough goods to last for years just to get a little discount. They thought they were saving some money.

However, it is only fair and sensible to assume that a department head will know more about the supplies and equipment used in his own department than will anyone else. To procure these supplies, provided, of course, they are not carried on the storeroom inventory, he should submit a purchase requisition to the purchasing agent who will order them via a purchase order.

From this it is easy to see why an institution should delegate its purchasing to one person only. The only possible exception to this might be the buying of perishable food, a task performed by someone well versed in the art, such as the dietitian. By using the centralized method, an institution will always be able to control its purchases, thereby saving a considerable amount of money, and—equally important—it can control stock movements.



WARD OR DEPT. _____ DATE _____
THE FOLLOWING ITEMS WHICH YOU REQUISITIONED ARE
TEMPORARILY OUT OF STOCK

| | STOCK NO | NAME |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

PLEASE RE-REQUISITION IN _____ DAYS

WARD OR DEPT. _____ DATE _____
THE FOLLOWING ITEMS WHICH YOU REQUISITIONED ARE
NOT CARRIED IN STOCK

| | |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |

PURCHASE
THEY MUST BE REQUISITIONED BY YOUR DEPT. HEAD

NAME OF HOSPITAL
PURCHASE REQUISITION

DEPT. _____ DATE _____
PURCHASE FROM _____ WHEN WANTED _____
CONSUMPTION RATE _____ AMOUNT ON HAND _____

| QUANTITY AMT. | UNIT | FULL DESCRIPTION OF ITEM WANTED | PRICE UNIT | EXT. |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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REMARKS SIGNED _____

**Above: These forms are to be filled out by the storekeeper at the time he receives requisitions for items that either are not carried at all or are temporarily out of stock. Right: Requisitions signed by the department head constitute the buyer's authority to purchase.**

## PURCHASE REQUISITION

A purchasing department that is well organized and functions properly will have several duties to perform as its share toward keeping the institution on an even keel. Its first duty is to the patient. It must procure the supplies and equipment needed to allay the suffering and to promote the recovery of the patient. The supplies purchased will necessarily be of the quantity needed and of the best quality in order to lessen the risks of a sudden breakdown in service.

Institutional purchasing invariably consists of three distinct types: departmental purchases, stores replenishment and major equipment purchases.

If the purchasing department has the inventory records the buyer will know what and when to buy. If the storeroom has the inventory records a purchase requisition will originate from there, or if the institution has an inventory control clerk he will initiate the purchase requisition for stock replenishment. Department heads will submit purchase requisitions for noninventory items used in their departments exclusively. The signed purchase requisition gives the information necessary for ordering and constitutes the buyer's authority to make the purchase.

A purchase requisition submitted by a department head to the purchasing department will give such information as the department's name, the date, the vendor's name, when articles are wanted (a reasonable amount of time should be allowed for procurement in case the item is scarce), how fast the item will be consumed (if known), the amount on hand (if any), the quantity needed, the description and specifications, and the price. If the department head has been in correspondence or conversation with the dealer and has any quotation data they must also appear on his requisition. It must be clearly understood that this procedure is for noninventory items only.

Requisitions for the replenishment of inventoried stores are treated somewhat differently. The department heading is marked "For Stock" so the buyer knows that the articles requested are regular inventory items and acts accordingly. Other headings on the form are then filled in, *i.e.* the date, where previously purchased (the buyer may find a better vendor), consumption rate and balance on hand (as shown by the inventory records), the quantity needed, the full description and specifications, and the last price paid for the last quantity purchased; the space marked "when wanted" is left blank.

This requisition is made out when the ordering point is reached and the quantity ordered must necessarily be sufficient to bring the stock level back to the maximum. The stock must not be allowed to go below the minimum if possible. When this point is reached the purchasing department must be notified immediately so that steps can be taken to expedite delivery.

Occasionally the buyer will get a better price by buying more than the

quantity specified. He will be advised as to how much more by the consumption rate shown on the requisition. He must, however, be careful not to buy an excessive amount, which is invariably a gamble unless he can properly store and protect the goods purchased and can pay for them without ruining the bank account.

The third type of institutional purchasing is for major equipment involving a considerable outlay of money. This should be done by a committee of four: the administrator or his assistant, the purchasing agent, the head of the department involved and a representative from the supply company selected. Thus the institution will obtain what it needs with little risk of future regrets. When the purchase has been decided upon and the purchase order made out, all three of the institution's representatives should sign each copy of the order. It is worth noting that if this purchase should fail to meet the needs for which it was intended no one individual can be blamed.

When property is sent away for repairs or reconditioning, a purchase order stating clearly just what is to be done should accompany it. It is seldom necessary to write a letter.

## PREPARATION FOR PURCHASING

When the buyer has received the purchase requisition, he must order or buy the goods requested. A departmental requisition will usually contain all the information he needs to place an order so all he does is issue a purchase order and send it to the vendor. However, a requisition for stock replenishment is an entirely different matter. The buyer must find a supplier who has the goods requested, who will make delivery fairly soon or when promised, who will sell at a reasonable price, and, above all, one whose honesty, reliability and integrity are above reproach.

The buyer must consider the item to be purchased carefully and buy the one that is the simplest and easiest to use and yet answers the purpose. Even a flashlight, for example, must be so uncomplicated that those who use it can change the bulb or batteries without breaking it. He must remember that the majority of people who use the supplies and equipment he buys have little, if any, mechanical ability; therefore, the mechanical things he buys must be of such nature that these people can make minor adjustments or repairs without ruining the equipment. The inventory records will give the specifications but they should not be so rigidly adhered to that improvements cannot be made.

If circumstances beyond his control force a buyer to purchase substitutes for regular items, he should consider carefully how well the substitute product will fit in with the procedures in use. If it will not fit without requiring such drastic changes in the procedure that further substitutes will be necessary, it should not be purchased. It is better to limp along until the regular item can be procured unless, of course, its manufacture has been discontinued. In this case someone else, preferably the department head concerned, should decide upon the substitute or change in procedure.

After all factors for making a purchase have been considered, a purchase order should be issued.

If the buyer gives a verbal order to a salesman or orders by telephone it is important that he issue a purchase order as soon as possible confirming the verbal order. This will help avoid any possible errors or misunderstandings and eliminate confusion in the purchasing and receiving departments.

The purchase requisition is always preserved for future reference; the simplest way is to clip it to the purchasing department copy of the purchase order.

## PURCHASE ORDERS

A formal purchase order is issued by the purchasing department or buyer for the purchase of commodities, service, repairs or anything of like nature.

This form should be simple and uncomplicated, stating clearly that it is a purchase order. It should include a number, the institution's full name and address, shipping instructions, terms or conditions of sale and a notation that invoices must be submitted in duplicate. This information is printed on the form. There will be blank spaces for the vendor's name and address, date, quantity wanted, description or specifications of the items wanted, and the price (if known, such as a quotation).

This form is made up of as many copies as necessary—at least four; the vendor receives the original and the purchasing department, receiving clerk and accounting department should each have a copy. Perhaps another department will need a copy, depending entirely upon the setup. For ease of handling, each copy is a different color and bears the department's name.

## QUOTATIONS

A purchasing department can save itself many headaches by asking for quotations on quantity purchases. The purpose of a quotation request is threefold: to determine if the items, or item, wanted are available; when they will be shipped, and the price. There are several methods for obtaining quotations. The most popular seems to be a printed form called "Inquiry for Quotation" which is sent to the prospective vendor. For local supply sources a telephone call or a salesman will achieve the desired results. For out of town supply sources a friendly business letter will get much better results than will a printed form. It may take a typist longer to type a letter than it does to fill out a form but the results obtained are well worth the extra expenditure of time.

## FILING AND INVOICES

All unfilled orders are filed separately in the "Unfilled Orders" file until they are completely filled; they are then filed permanently in alphabetical order in the "Completed Orders" file. It is advantageous to make a record of all purchase orders issued in numerical order with the date and vendor's name in a purchase record book because it is so often necessary to locate a purchase order when only the number is known. It is then a simple matter to look up the number, see who the vendor is, and get his order out of the file.

As merchandise is received the receiving clerk makes out a receiving slip and sends it, together with the packing list and freight bill, to the purchasing department where it is compared with the purchase order. On this purchase order are written the date received, the quantity received, and indication that the specifications are correct. This set of papers is then filed in the "Awaiting Invoices" file until the invoice is received.

When the invoice is received in the purchasing department, it is checked against the purchase order and receiving slip and any discrepancies are noted. If there are none it is approved and sent, with the receiving slip and freight bill, to the accounting department for payment. This purchasing department copy of the purchase order is then clipped to the

duplicate invoice and filed away in its proper file.

Because invoices are so often received ahead of the merchandise a file for "Invoices Awaiting Merchandise" is needed.

When the purchase order is completely filled it is filed away in its permanent file. If it is not completed it goes back to the "Unfilled Orders" file. It is important that invoices be processed promptly so as to take advantage of any available discount. Two per cent by the tenth adds up to many dollars in a year's time.

### CONTRACTS

Sometimes a buyer can obtain a really good price on items the hospital consistently uses in large quantities by contracting to purchase a large quantity over a certain period of time but taking and paying for them only as needed. Under this method the dealer must carry the large inventory while the institution carries only a small one. Obviously, this method keeps the institution from tying up a great deal of money and still enables it to save on its purchases. This is an excellent way to buy provided you can find a dealer willing to make such a contract. A manufacturer is more likely to do this than is a dealer.

Another method in popular use is to contract to buy a large supply of goods and have them shipped in fixed quantities at fixed times over a fixed period of time and pay for them as received. This is not always a good method because supplies usage is not constant but varies. There will always be the risk either of running out of the item before the next shipment arrives or of becoming overstocked, which often leads to a money loss.

It is part of the purchasing department's function to follow up the orders it places in an effort to determine why they have not been filled or when they will be filled. It is sometimes necessary to cancel an order with one company and place it with another which will make quicker delivery. This procedure includes tracing shipments or parts of shipments that have strayed during transportation.

The purchasing department must be prepared to make adjustments with vendors who have made unsatisfactory transactions. Another duty of this department is to dispose of damaged, obsolete or surplus supplies and equipment and sometimes to scrap material in a way that is least disadvantageous.

Occasionally the storeroom will run out of certain stock items despite every effort to prevent it. If the head storekeeper is supplied by the purchasing department with the two forms illustrated on page 53 a great deal of misunderstanding will be eliminated.

When someone writes a stores requisition for items that are temporarily out of stock, the storekeeper will fill out the form for items "Temporarily Out of Stock" at the time he fills or receives the requisition and gives or sends it to the person signing the requisition. The same procedure is followed for items not carried in stock except that he uses the form for items "Not Carried in Stock."

Some institutions use a "back order" system or stores control but this makes unnecessary extra work for busy storekeepers unless they have sufficient help and equipment to handle such a procedure. The method just outlined will give results that are equally satisfactory and cause less trouble.

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# Mechanical Suture Winder

**WILLIAM T. GRANT, M.D., and EDWARD C. OBERC, M.D.**
Division of Surgery, Huntington Memorial Hospital, Pasadena, Calif.

A METHOD is presented for preparing multiple sutures of equal length mechanically, rather than by winding the suture about a board by hand. The mechanical method has been welcomed with enthusiasm by the surgical nurses in our hospital where the apparatus has been in use for the last eighteen months. They find that enough sutures to last for two days can be prepared in twenty minutes.

Basically the instrument consists of an electric motor with a 15 to 1 right-angled reduction gear (Fig. 1). The wooden base measures 5½ by 12 inches. At one end a slot is cut, the center being in alignment with the shaft of the motor. A grooved 6 inch wheel, with a notch in it, fits over the slot and is attached to the motor shaft by a collar having a set-screw to facilitate removal. A 4½ inch rod is driven into the other end of the wooden base to hold the spool of thread. The thread is brought through a wire loop to keep it in line with the wheel and is attached at the notch of the wheel by a small catch. A strap spring mounted on a rigid upright holds the spool on the vertical rod.

An adapter to accept the shaft and spool of the surgical sewing machine may be mounted on the motor shaft instead of the large wheel (Fig. 2).

When running, the wheel rotates six times per second, and sutures of between 15 and 16 inches in length are obtained. To unwind a 250 yard spool of No. 50, white cotton thread consumes about fifty seconds. Other sutures, such as silk and nylon, can be wound with equal facility. At present two 250 yard spools are unwound at one time by placing the second spool above the first.

The advantages of the apparatus are obvious. The arrangement is simple to operate and requires practically no maintenance. The device has been found to save much time in cutting surgical suture material and to turn a long task of drudgery into a few minutes of easy work.

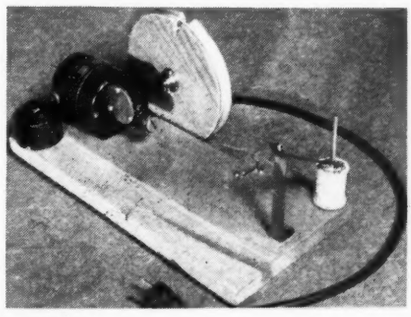


FIGURE 1

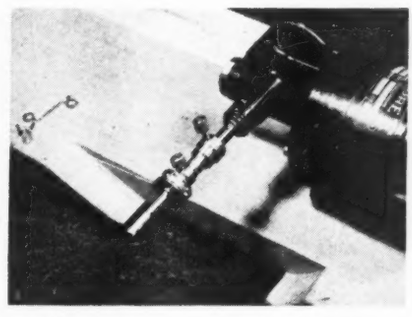
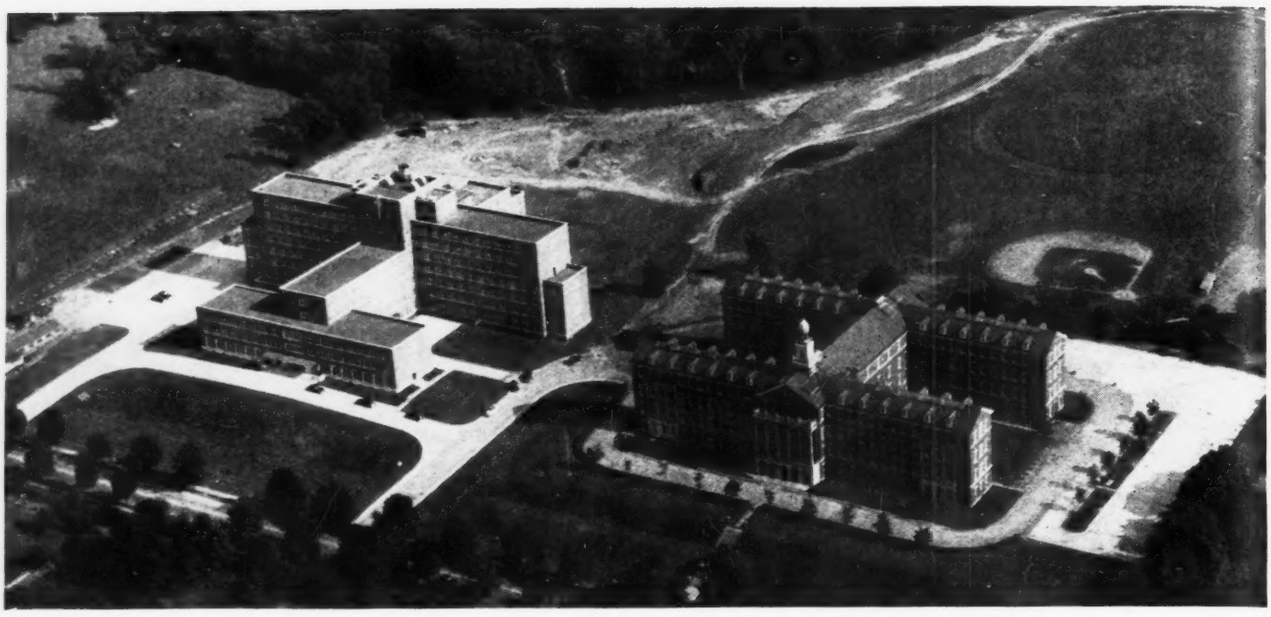


FIGURE 2



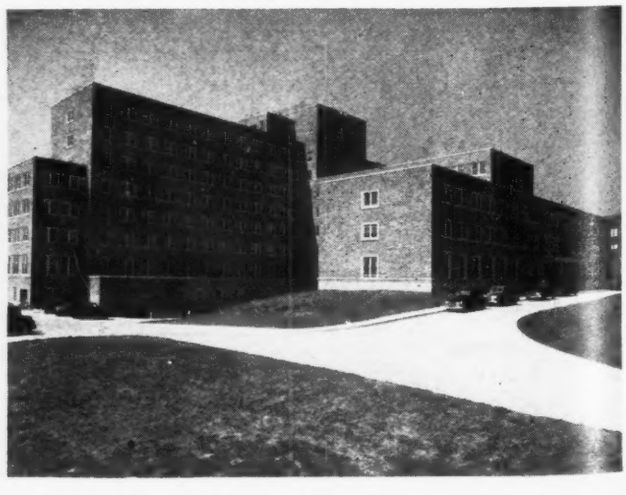
AERIAL VIEW OF THE NEW GEORGETOWN UNIVERSITY HOSPITAL, WITH THE MEDICAL COLLEGE AT RIGHT.

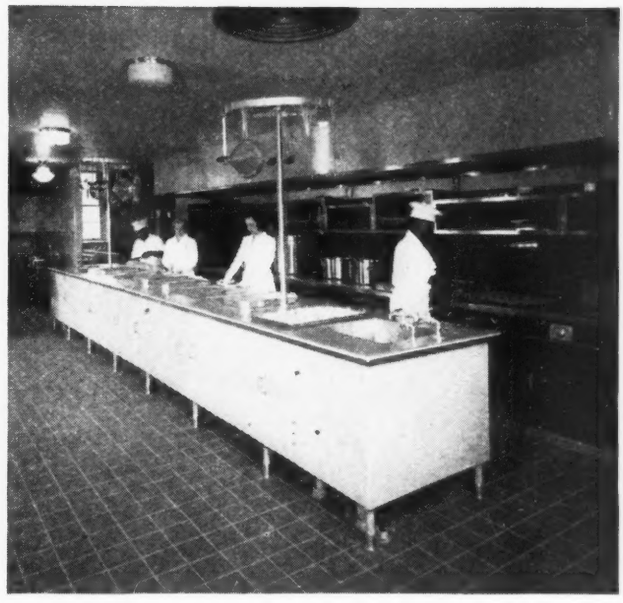
# THE OLD GEORGETOWN YIELDS TO THE NEW

GEORGETOWN University's new 407 bed teaching hospital stands substantially completed in its 6 acre tract adjacent to the Medical and Dental Colleges overlooking Reservoir Road in Washington, D.C. The hospital was started as a war public works project and ground was broken on Dec. 18, 1944. It cost approximately $3,600,000 of which $2,850,000 was contained in a Federal Works Agency grant, or about $8832 per patient bed. The first patients were admitted to the new hospital last July 21.

The hospital rises seven stories in its center portion, which is surmounted by the machinery room, actually an eighth story, and is adorned at its highest point with a great cross standing in relief against the masonry, the single decorative sculptural incident. An Act of Congress amending the District building code was passed to permit the proposed height.

Construction is of reinforced concrete frame with brick curtain walls and stone trim, and there are two floors below the ground level. The entrance and lobby are finished in Tennessee marble; the corridors are floored with asphalt tile; floors in the operating rooms are terrazzo. Plans call for four passenger elevators, one service and a freight elevator; a dumbwaiter connects the pharmacy with the nurses' stations on each floor. There is also a sidewall



All Photographs From Federal Works Agency.

**HARRY HEWES**
Washington, D. C.

elevator. Kaiser, Neal and Reid of Pittsburgh were the architects, and the John McShain Company of Philadelphia had the general contract.

Besides the 407 beds there are 123 bassinets, six delivery and labor rooms, nurseries, 13 operating rooms and all of the other departments, sections and appurtenances of a fully equipped acute general hospital. There are 127 single private rooms, including the Sisters' accommodations on the seventh floor; 124 patients' beds in 62 rooms, 112 beds in 28 wards, 13 beds in three pediatrics rooms, and 31 beds in observation wards and doctors' suites.

The Sisters of Charity of Nazareth (Kentucky) administer the new hospital and 20 members headed by Sister Mary Antonella as administrator and Sister Superior, and Sister Agnes Miriam, director of nurses, arrived in Washington early in June. This religious community was founded in 1812 and its nursing tradition dates back more than a hundred years to 1831.

The old Georgetown University Hospital had its origin about 50 years ago when the medical faculty decided to establish a teaching hospital on N Street between Thirty-Fifth and Thirty-Sixth Streets, N.W., on a site provided by the university. One of the units for 24 patients was completed in August 1898. The building and furnishings cost $27,000. There were accretions and enlargements of the hospital plant and nurses' home during the years and its capacity at the time of its peak service was 265 patient beds under conditions of severe crowding. The old hospital will be converted into dormitories and faculty offices.

Opposite Page, Left: Entrance of the new Georgetown University Hospital. Right: The new teaching hospital was opened for patients on July 21, 1947. It contains 407 beds, 123 bassinets, 13 operating rooms, six delivery and labor rooms, nursery and all the departments and appurtenances of a fully equipped acute general hospital. Above, Left: A corner of the nursery, showing arrangement of cubicles. Above, Right: The kitchen of the new hospital. Right: Removing patients from the old hospital on N Street to the new institution near the medical and dental colleges overlooking Reservoir Rd.

# CONSIDER THE POSSIBILITIES

## of decentralizing hospitals to minimize the hazards of war, nature and traffic

**CLEMENT C. CLAY**
Director
Course in Hospital Administration
Yale University School of Medicine
Department of Public Health
- New Haven, Conn.

IT'S the largest group of hospitals in the world." "We have the greatest number of beds of any similar institution." "Our hospital is the tallest one in America." North, south, east and west—wherever one travels about the country these days, one is likely to hear such comments. Boasting of colossal size is a good old American custom on which Hollywood has no monopoly; but should we in the hospital world continue to fall for it?

No one has made a serious and detailed study to prove that immense hospitals and huge medical centers are of greater benefit to the patient than are institutions of moderate size. The patient, after all, is recognized as the ultimate excuse for the existence of any hospital, large or small. Available cost studies have not indicated that large hospitals are always more efficiently and more economically operated. There may be a point at which increase in size is a liability rather than an asset. Further investigation is desirable.

### TENDENCY TO POOL RESOURCES

Countrywide, there appears to be a tendency for hospital consultants, architects, administrators, trustees and others to advocate pooling the hospital resources of a community. Their common plea is: "Instead of building separate institutions in various parts of the city, let's get together and erect our new institutions adjacent to one another to form a g-r-e-a-t medical center." The planners may advise addition of 200, 500 or 1500 beds to an existing institution rather than the erection of new and separate hospitals on a neighborhood basis.

The hospital world may be out of step; for we read of industry's urge to decentralize—to disperse its facilities. The news reports tell us of the army's interest in underground factories and in the creation of industrial facilities away from the large centers of population. Perhaps we should consider some of the possibilities before concentrating the hospital facilities of a city.

In one city in the Midwest, a large proportion of the voluntary, nonprofit hospital beds are located in institutions in a small area through which a busy railroad freight line passes in an undercut. The explosion of a tank car in the right place at the right time would decimate the region and leave that city virtually without hospital facilities for a large segment of the population. Texas City may never have thought of the danger of an explosion in a ship in its harbor, but the mere shell of a city today bears testimony to the power of such a blast. Other communities may be blind to the possibilities of a similar catastrophe, but no section of the country is free from comparable hazards.

Nature, a whimsical old girl at times, is capable of strange pranks. A hurricane or cyclone has been known to cut a swath of death and destruction through a town leaving untouched areas on either side. The lone medical center could be destroyed or it could be in the "safe" area. It might be a case of divided we stand, united we fall—contrary to the accepted adage.

World War II was described as an "all out" conflict while it was in progress. Civilians and their nonmilitary establishments may not have been the actual targets of attack, but the German V-1 buzz bomb and V-2 rocket had no device to direct them to military installations. Mass bombing raids on London, Naples, Berlin, Tokyo and dozens of other cities by opposing forces exhibited no selectivity capable of sparing hospitals, churches, schools and homes. When the atomic bomb left a B-29 on that fateful day over Hiroshima, it was addressed "Hiroshima, General Delivery." Death paid the C.O.D. charge.

Pearl Harbor felt the lightning blow of Mars only on Dec. 7, 1941; but the Continental United States was spared completely. Fortunately or otherwise, only a few million men and women in our armed forces overseas had the unwelcomed opportunity for personal observation of the destructiveness of modern warfare. Back home, few residents of New York or Chicago or San Francisco or points between had any true conception of that phase of the war in spite of the newsreels, letters, magazines, papers and radio. It is only human, perhaps, to believe that it can't happen here.

### BUT IT CAN HAPPEN

The military experts warn us, however, that our own cities will be the first objectives in the next war. "If World War II was an 'all out' conflict," they predict, "it was only a 'popgun duel' compared to what we may expect in World War III." We may hope and pray for lasting peace. We may have unbounded faith in the ability of the United Nations to keep the world free from war. History should have taught us costly lessons on several occasions, nevertheless, lessons which proved that the words of our military advisers cannot be ignored. We amortize our hospital buildings over a period of fifty years, more or less. Is it realistic to assume that they will be untouched by war in their normal lifetime?

After the discussion of the effects of disasters in such dire mood, it may be an anticlimax to approach another side of the problem; but it deserves consideration. All too often, we concentrate our hospital facilities in the most congested area. We give little thought to the comfort of our patients when traveling to or from the hospital and dispensary. We ignore the problems of the relatives and friends who will visit the patients and who must board packed cars or buses or seek unsuccessfully, all too often, for places to park their automobiles.

We overlook the fact that our own medical staff members and employes suffer similarly with regard to transportation facilities and traffic difficulties and that employes are unable to find places to live within a reasonable distance from the institution because there are no neighboring residential areas or because existing accommodations are unsuitable. After all, the prospective patients live for the most part in residential areas; so why not have the hospitals more accessible to them? A location in a congested area impedes delivery of supplies, for another thing.

Many communities have demonstrated the feasibility of locating hospitals away from the center of town, as long as good transportation facilities are available. It could be pointed out in passing that the hospital's investment in land may be considerably less in such cases.

# ADMINISTRATIVE INTERN'S CONTRIBUTION

**FRANK R. SHANK**
Assistant Superintendent, University of Chicago Clinics

UNTIL recent years little has been thought and said about the administrative intern's contribution to the hospital. This is probably due to the fact that until the past two or three years there was only one university graduating hospital administration students. This university enrolled a maximum of 10 students per year and, therefore, there was not a demand for a large number of hospital administrators to give the subject consideration. There are a potential 100 administrative interns to be offered to the hospital field in June 1948 so it now behooves administrators to give consideration to the benefits to be derived by them from such a program.

There are many advantages to both the hospital and the administrator. The following is a possible list of advantages to the proctoring hospital.

The first contribution is that the administrative intern brings into the hospital a fresh point of view. The intern is likely to have a "why?" for everything that is done in the hospital, thus causing the administrator and the department heads to clarify their thinking many times as to why certain procedures are performed as they are.

The intern will have a tendency to review procedures and technics of the hospital in the light of recent studies. He has, during his year of academic training, visited many hospitals and has observed how other hospitals have performed. It is true this is but a superficial observation and most hospitals visited will be likely to show the best side of their institutions; nevertheless, it is probable that the intern has seen somewhere a better and easier way of doing some things simply because every hospital does like to put forth its best foot and if one has a department that is running smoothly it will be one of the first to be shown. Then, too, his studies in his academic year will be of aid to the intern in pointing out many possible discrepancies. It is also true that many things learned in the academic year cannot be applied in every case but they will be of great aid in solving many problems.

The intern is someone with whom the administrator can discuss ideas he may not feel at liberty to discuss with many of his subordinates. The higher up the ladder of achievement one goes the fewer become the number who can discuss the overall problems intelligently. There are many who can discuss one department or one phase of the hospital but few subordinates see the hospital in its totality and can discuss the problem of one department in the light of all divisions of the institution. This is one thing that the intern should be able to do.

The administrator should feel free to discuss his ideas with the intern and feel with a considerable sense of security that his discussions will not be divulged to others. An administrator often likes to think out loud and an administrative intern can be of assistance in helping the administrator to reach the most satisfactory solution.

The presence of an administrative intern may cause the board of trustees to recognize more fully the importance of *good administration* in the hospital. Many boards of trustees have not appreciated that hospital administration is a profession and requires training. The presence of an administrative intern in their hospital will increase this appreciation.

The same thing may be true with regard to the attitude of the medical staff toward the administrator. In many places the medical staff looks down on the hospital administrator but when he starts to train administrative interns they of necessity give more prestige to that profession.

Furthermore, the intern goes into the hospital to learn. He is not there to instruct the department head. He is not there to instruct the administrator but to serve as an assistant and as a student. An intern can approach the department heads in an informal, semi-official capacity and learn things about their departments which might escape an administrator or his assistant. Once the intern has gained the confidence of the department heads they will freely discuss their problems and ideas with him. The administrative intern is not a fifth columnist or a stooge. He is not a spy nor should he approach a department head with the idea of obtaining confidences to divulge to the administrator.

The intern may cause the administrator and the department heads to analyze their individual positions (and various situations which arise) more carefully; for they will have to think more carefully if they are going to make satisfactory explanations to him. The answer: "O we have done it this way for years" will not suffice. He will want to know if there is a better way of doing the work. This may be the first time that anyone has ever questioned their methods, and it may have a wholesome effect.

The intern should approach the de-

partment as a student. He should not discuss the functioning of that department so as to lower the prestige of the administrator or to intimate in any way that the department head or the administrator does not know how to operate the department or the hospital efficiently.

A second contribution that an intern can make to the hospital is that he can compare the theoretical with the practical. Many routines become traditional in a hospital. They were instituted to meet a certain need but now the need may not even exist and yet the routines are religiously conformed to.

Newer methods taught can be tested against the present method used. An intern can bring to the hospital many of the latest ideas of hospital administration for consideration of the administrator. These need not be adopted necessarily but the administrator is stimulated to think of innovations and to keep abreast of new developments. The university is constantly trying to improve its hospital administration program by teaching the latest improved methods. There is a place for the practical and a place for the theoretical.

### CAN ALSO DO THE FOOTWORK

A further contribution to the hospital by the intern is that he can solve minor problems and do footwork for the administrator. The intern can make many administrative decisions. These would be problems that do not require too much background and on which the decision is not likely to be of consequence to or to affect other departments. One example would be a dissatisfied patient *versus* a dissatisfied department head. When it is possible the intern should be given the opportunity to handle short term problems until he has developed to the point where he can handle major problems.

The administrator is called to make many trips to various parts of the hospital daily to check on minor things, such as the progress on certain work, or a bottleneck in some service, or to see that certain emergency cases are handled quickly. The administrative intern could be sent on many such errands, thus relieving the administrator of many details.

There is a never ending flow of forms and questionnaires to the administrator's desk. The intern can save the administrator invaluable time by filling these in as much as possible and consulting with the proper department heads for additional information. Forms and reports used as controls and for information by the administrator could be reviewed by the intern to discover their continued value. The intern has the time to look into the history, purpose and value of reports that come to the administrator's desk. While it is true that the intern will not be qualified in some cases to judge as to the value of some reports as controls he will be able to ascertain the worth of all but a few.

A fourth major contribution of the intern is that he can make special studies. The administrative intern has no routine duties (or at least he should not have) and, therefore, is free to engage in special studies which the administrator or assistant administrator cannot undertake because of lack of time. However, these special studies, forms and questionnaires should not consume all of his time.

The intern can hold his solutions on a higher theoretical level than if he had to execute them. When the study has been completed the intern has an opportunity to check his conclusions with the administrator. Many administrators will find a problem solved on a highly theoretical basis rather stimulating and the hospital will assume a spirit of vitality and alertness that perhaps it would not otherwise have. When the intern has his office adjacent to the administrator's office he can be of greater assistance, partly because of his proximity and partly because he absorbs more of the "atmosphere" and "activities" of the hospital and is more familiar with its functioning.

It is commendable to have one conference daily with the preceptor so that the administrator will be made more aware of what the intern is doing. Some interns are mature and need little supervision but it is still desirable to take a few minutes daily for checking, reviewing and planning. The intern is also in need of something intangible that only a close association with the administrator will give him.

A fifth contribution is that the administrator often originates an idea and assigns the intern to execute it. This sort of arrangement encourages more creative activity on the part of the administrator and gives the intern practice in administrative functions.

A sixth contribution is that the administrative intern can pinch-hit in an emergency. I do mean emergency. It is not just to the intern or the hospital to hide the intern in one department. I do not believe an intern should spend more than four weeks in any one department. The hospital has so many phases to be studied in the internship in order to get a good overall picture that pinch hitting must be kept at a minimum. The hospital is also the loser when the intern is restricted by departmental duties. He loses his overall, creative point of view and becomes engrossed in details. The administrator and department heads will miss his theoretical and academic approach. So often the administrator loses this same spirit in the mass of details he is required to wade through.

One of the primary functions of a hospital is education. Therefore, training an administrative intern enables the hospital to broaden the scope of its educational work.

### COMPENSATIONS ARE MUTUAL

A few points must be borne in mind by the intern. He will get as much out of an internship as he puts into it (provided the administrator does not lose him in some department as a pinch hitter) and this should be on behalf of the person who made his internship possible. The same principle applies to the hospital and the administrator. The compensations are mutual to both intern and administrator.

The intern must respect the administrator or the department heads and employes will not respect him. The intern can be of inestimable aid in helping to solidify the administration or he can do much to cause its disintegration. The intern is a goodwill ambassador for his administrator and should conduct himself so that his association is desired by the department heads and employes of the hospital. The intern must carry a positive, constructive and cooperative attitude. He must be careful of what he says and does. He must avoid leaving a feeling, or even suggesting or intimating, that all is not well.

I once read a poem two lines of which I remember and which I think are well worth any intern's consideration. They are:

*"Tear not down another's structure,*
*Thinking thus to build thine own."*

The intern is a builder, not a wrecker. As a builder, the administrative intern's value to the hospital is inestimable.

# THE GENERAL PRACTITIONER

## Indispensable Man of the Medical Profession

**DAVID LITTAUER, M.D.**
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THE general practitioner is coming back into his own. No longer is he considered the forgotten man of medicine. Specialization has gone so far that the indispensable basis of the medical profession, the general practitioner, has been in danger of disappearing. Strenuous efforts are therefore under way to restore him to his proper place in the scheme of medical practice.

The American Medical Association has recently created a section on general practice. State and county societies are actively encouraging the formation of general practice groups. A magazine and a professional academy devoted to the interests of the general practitioner have been established. A General Practitioner's Medal was awarded to a physician at the Cleveland interim session of the American Medical Association last month.

### HOW TO INTEGRATE HIM?

This reversal of attitude toward the general practitioner has posed a problem to hospitals, which have become the citadel of specialized medical practice during the last generation. How is the "G.P." to be integrated into a professional staff which is organized for specialization? Should the nonspecialist have a separate department, or should he be assigned to minor positions in existing departments? If there is a distinct general practice grouping, should it, too, be considered a specialty?

Menorah Hospital, Kansas City, Mo., was faced with this problem a year ago when the medical staff was undergoing postwar reorganization. Menorah is a general hospital of 160 beds and 26 bassinets, admitting between 5500 and 6000 cases yearly. About 10 per cent of its patients are medical indigents. A small percentage of part pay patients is also admitted to the inpatient free service. The hospital has no university affiliation. An expansion program which includes development of an outpatient clinic, facilities for long term care patients, and provision for medical research is in the offing.

Before the war the medical staff consisted of a number of surgeons, internists, obstetricians and other specialists, as well as general practitioners, but they were not organized in a formal departmental pattern. The hospital was approved for internship.

Inasmuch as the hospital was only 10 years old at the beginning of World War II, its staff consisted predominantly of men acceptable for military service and an unusually large number volunteered or were called. Short cuts and compromises in professional work were inevitable.

As physicians returned from service and brought with them fresh points of view, and as the men who remained behind had an opportunity to catch their breath, it became apparent to them that the hospital staff was not carrying out its full responsibilities. A special committee was appointed to study ways and means of improving staff functions. It recommended departmentalization so that specialist skills could be utilized to the full; organization of the free inpatient service, and the private services insofar as possible, into a teaching unit; development of professional standards and training programs adequate to obtain approval for selected residencies, and preparation of the staff for the increased responsibilities posed by the projected expansion.

The surveying committee found that 25 of the 60 active staff members were certified by their specialty boards, with a half dozen more preparing to take the examinations; all of the senior surgeons were fellows of the American College of Surgeons, and eight physicians did not confine their work to a specialty or group of allied specialties (like eye and ear, nose and throat) but were doing general practice. The men in this group treated most medical diseases, delivered babies, treated children, and did their own minor surgery. Some performed tonsillectomies and a couple occasionally ventured into the fields of major surgery and operative obstetrics.

It was apparent that if general practitioners were incorporated into a formal departmental structure of specialist groups, present and projected, the professional and educational program of the hospital would be impaired. On the other hand, it was believed desirable to give some recognition to the members of this group in the staff structure.

### Department of General Practice

On the recommendation of the committee a department of general practice was established on a par with 10 other professional departments of the staff (dentistry, medicine, obstetrics and gynecology, ophthalmology, neurology, pathology and laboratories, radiology, otorhinolaryngology, pediatrics, surgery). An alternate suggestion that the staff be divided into two major groups, a specialist group which would include men who limited their practices to the specialties, and a nonspecialist group which would include only general practitioners, was discarded. It was believed that such a step would create one top heavy and one weak group; it would artificially set the general practitioner aside rather than integrate him into the whole staff (an active-courtesy staff grouping under another name), and it would not yield any advantage to the physician or to the

hospital over creation of a department on a par with the others.

The new department of general practice was authorized the grades of head of department, attending, associate and assistant, as in the case of other departments.

It was provided that members of the department of general practice who desire to be assigned to the charity service for the care of free inpatients can be so assigned if the head of the specialist department approves. In such cases the general practitioner continues to be carried in the department of general practice but is detailed to work in the specialty department of his choice. If he is detailed to the department of medicine, for example, he will make rounds in company with the attending internists who are on service. He will attend medical department meetings and will participate in seminars of that department. If assigned to the department of surgery, he may assist at operations which are not in conflict with those assigned to the resident surgeon and take part in rounds and other activities of the surgical department. It is understood that this training will not qualify the general practitioner to become a specialist, but it is most beneficial in filling in his background to do general practice.

The eight physicians whose records indicated that they were doing general practice were assigned to the newly created department. Only one objected. He subsided without comment when shown a list of the types of cases which he had treated during the previous year.

### Advantages to the General Practitioner

The most significant immediate gain to the general practitioner was a tremendous boost in morale. He is no longer a lonely soul, tolerated by his colleagues only because he is a major source of referred work and consultations. He has his own department in which he can attain seniority. He has been appointed to committees of the medical staff, instead of being passed over in favor of those who have been identified as "very important people" because they are specialists in a field of medicine but who in reality may have few qualifications for, and little interest in, the business affairs of the staff.

He takes an honorable part in the professional and educational programs of the staff. He can present or discuss cases at clinical or pathological conferences. He takes his turn in the weekly series of lectures to the house staff, being particularly well qualified to discuss such subjects as physical signs, differential diagnosis, treatment of emergencies, and the like.

As previously noted, when detailed at his own request to work in a specialist department on the free service, he is able to improve his diagnostic and therapeutic skills. Four of the eight physicians presently in the department of general practice requested such assignment during the first year: two in obstetrics, one in orthopedic surgery, and one in general surgery. Concern which was expressed initially that such assignment would deprive residents and interns of valuable training has proved groundless.

Six months after the hospital had created this new department, the local county medical society sent letters to each hospital asking that it nominate a representative to assist in the development of its newly formed section of general practice. The head of department was inevitably the hospital's choice.

### Advantages to the Hospital

Hospitals today must ensure that their private and indigent patients alike receive the finest possible care. In creating a department of general practice, the limitations as well as privileges of this group of physicians are more clearly defined and more easily controlled. Since the free inpatient services are no longer cluttered with men who have little to offer in the way of specialty skills, the indigent patient is rescued from the danger of receiving mediocre treatment. General practitioners are not permitted to perform major surgery or operative obstetrics. Nor may they qualify as consultants in such operative conditions as cesarean section and curettage; the obstetrician must consult with a specialist in the field of medicine, or surgery, indicated by the reason for the operative procedure.

The training program of the hospital for its house staff has been strengthened. The resident or intern is assured both specialist training and the fund of information which can be obtained from the general practitioner in proper perspective. It has already been observed that the latter takes part in educational activities in which he is qualified. In addition, the head of the department of general practice, who has the lore of many years' experience at his fingertips, is available for consultation by any member of the house staff. This would not have been possible if he were just another "G.P." on the fringe of the active staff.

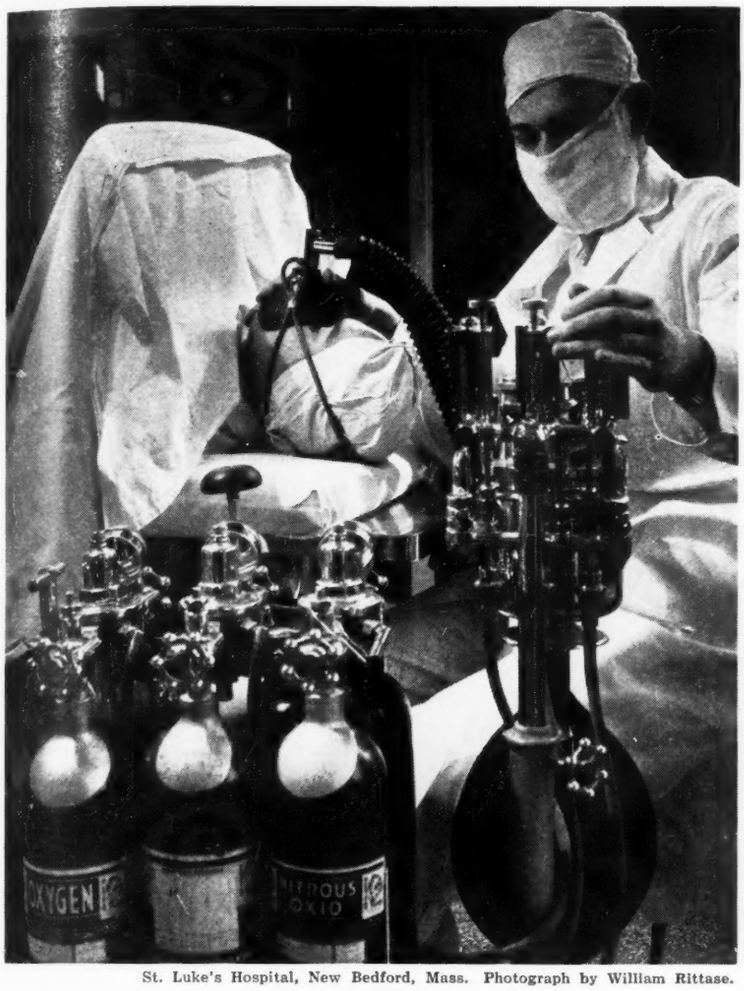
### Future Program

The next phases of development of the rôle of the general practitioner are discernible. The general privileges and limitations of the nonspecialist will be more clearly defined and modified in accordance with the experience and qualifications of individuals in the group. For example, recent study of the cases of a physician assigned to the department of obstetrics and gynecology indicates that obstetrical and gynecological work comprised only 25 per cent of his practice during the last year. This physician has, therefore, been transferred to the department of general practice. Because he had six months' postgraduate work in obstetrics he has been permitted to continue such procedures as application of high forceps, but he cannot perform major gynecological or obstetrical surgery.

The hospital plans to establish an outpatient clinic; the nonspecialist will logically staff the general medical or receiving clinic through which all new patients pass, and he will also have the opportunity of working in one or more of the specialty clinic departments.

If the American Medical Association approves a residency in general practice, the hospital plans to establish one. Such a residency could include periods of training in pathology and laboratories, radiology, anesthesiology and physical medicine, as well as the clinical services. Experience in all of these branches will stand the general practitioner in good stead.

As he is integrated more closely into the professional organization of the hospital, it is expected that he will serve in proportion to his numbers on committees of the staff and among its elected officers. Certainly, the community will reap large dividends when the general practitioner's place in the hospital is fully established, since no specialist has ever quite been able to take his place in the personal relationship which is so necessary between physician and patient.




St. Luke's Hospital, New Bedford, Mass. Photograph by William Rittase.

# CONTROL of ANESTHESIA HAZARDS

**GEORGE H. BUCK**
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IN 1944 there was published by the National Fire Protection Association and distributed to the hospitals of the country through the American Hospital Association a vitally important pamphlet entitled "Recommended Safe Practice for the Use of Combustible Anesthetics in Hospital Operating Rooms." A competent committee of experts labored long and arduously to develop these recommendations. They had the official sanction of the American Hospital Association.

At the time of distribution, it undoubtedly was the thinking of those responsible that placing this pamphlet in the hands of all hospital administrators would in a large measure solve the problem of operating room explosions. Unfortunately, this has not proved to be so.

On the contrary, three years of experience has demonstrated some of the recommendations impractical of enforcement and some others of questionable value. In regard to the latter, it is interesting to note that the two members of the committee of the National Fire Protection Association which prepared the recommendations who are most intimately associated with the problem from a practical standpoint, being practicing medical anesthesiologists of national repute, disagreed with certain portions of the standard, and one in particular requested that he be publicly recorded as voting in the negative.

In addition, because of the existence of this set of standards as an official recommendation of the National Fire Protection Association, hospitals in several sections of the country are now facing the immediate prospect of replacing their present operating room lighting equipment with the installation of explosion or vapor proof, ceiling suspended operating room lights at a cost of approximately $800 per room. This measure is now considered by the safety committee of the A.H.A. Council on Hospital Planning and Plant Operation to be unnecessary for the maintenance of safety in the presence of combustible anesthetics as used in hospital operating rooms and, therefore, an unnecessary and wasteful expenditure of large sums of money.

The reason for the existence of this unfortunate situation is that the recommendations of the N.F.P.A., the organization responsible for writing the national building codes, become the pattern for local building codes, executed by local enforcement officers. The recommendations contained in the pamphlet in question do not themselves constitute law, but as long as these standards represent the latest official statement of the National Fire Protection Association on the subject they can and will be used as a basis for local codes and ostensibly can be enforced.

Thus, the situation as it exists today with respect to the control of the hazards of combustible anesthetics in hospital operating rooms is in urgent need of improvement, both from the standpoint of providing practical and enforceable safety measures and also from the standpoint of the cost of providing the safety which we all desire.

When, about two years ago, the American Hospital Association began receiving calls for help from hospitals which had been ordered by local fire marshals and building inspectors to

Condensed from a paper presented at the American Hospital Association convention, St. Louis, 1947.

install explosion-proof ceiling lights in their operating rooms (some were new construction, others were contemplating no changes), the problem was referred to the safety committee of the Council on Hospital Planning and Plant Operation for study and recommendation.

It is understandable, of course, that a matter as serious as that affecting the incidence of explosions in hospital operating rooms must necessarily be investigated with deliberate thoroughness and any recommendations be examined and reexamined before final acceptance. The National Fire Protection Association is noted for its thoroughness and exactitude and since it is being asked to modify and lessen the stringency of certain of its previous recommendations, it is proceeding with exceptional caution.

#### COMMITTEE RECONVENED

Its committee on combustible anesthetics is being reconvened to consider the recommendations being submitted to it by the American Hospital Association safety committee working in conjunction with its own advisory committee of technical experts. It is hoped that by June of 1948, the time of the annual meeting of the N.F.P.A., a revised code of safe practice for the use of combustible anesthetics in hospital operating rooms will be ready.

It is not my intention to delve into the technical details comprising the national electrical and combustible gas codes which serve as the foundation of the operating room safe practice code or to give a complete set of standards the observance of which will maintain a reasonable degree of safety in operating rooms. Both sets of information are readily available in the N.F.P.A. pamphlet, "Recommended Safe Practice for the Use of Combustible Anesthetics in Hospital Operating Rooms," presently under study for revision, but which in the main contains a wealth of useful detailed technical information.

Rather, I would like to present the exceptions which have been taken to the present code and the principles underlying the new approach to the problem.

The present thinking of the safety committee is as follows:

1. The present code defines a hazardous location (one requiring the use of explosion or vapor proof lights) as the entire room in which combustible anesthetics are used or stored, including an area 10 feet outside the door of such room and to a height of 7 feet above the floor in this area. An exception is made in case the room is ventilated in accordance with certain specifications, including the minimum rate of 20 cubic feet of air per minute per person, in which case the hazardous zone inside the room is considered as extending to a height of 7 feet above the floor.

The 7 foot level for delimiting the hazardous zone is arbitrary and indefensible. A 5½ foot limit is more plausible in the light of expert opinion on the diffusion and explosibility of hydrocarbon gas and unquestionably so in the case of ether, which is much heavier than air and consequently hugs the floor. Most present nonexplosion-proof lights are maneuverable below the 7 foot level and not the 5½ foot level. The use of the 5½ foot level, then, would permit the use of present nonexplosion-proof equipment without compromising the present electrical code.

The requirement of forced draft ventilation to exclude any portion of an operating room from being considered a hazardous area is an unnecessary precaution and impractical of enforcement. This regulation would force 75 per cent of the hospitals in the country to install either ventilating systems or explosion-proof lights. Careful study has disclosed not a single case of an anesthetic gas explosion caused by a ceiling suspended operating light. In the face of this experience, hospitals would be foolhardy to make the capital investment to comply with the regulation in either way, and continual disregard of this provision will encourage disrespect for desirable features of the code.

A closed storage room for anesthetic gases should be considered a hazardous zone in its entirety because of the possibility of large scale leakage filling the room with an explosive mixture. Gases should be stored in a building that does not house patients. Reducing gases should be separated from oxydizing gases by a blank wall. Not more than twenty-four hours' supply of gas should be stored in the operating unit.

2. The present code combines regulations affecting the physical plant with those controlling administrative procedures. These two aspects of safety are best dealt with separately, as separation better emphasizes the need for administrative control. It is believed that neglect of the administrative details of a safety code has more frequently been the cause of explosions than have specific inadequacies of the physical plant.

3. The handling of the problem of static electricity by the present code is believed inadequate.

The present code recommends intercoupling. Although intercoupling does eliminate the danger of electrostatic discharge in the operative field, provided no additional person enters the field, it is actually a source of danger when the entire operating room is taken into consideration. Conductive floors and conductive contacts for all persons and objects on the floor are believed to be the only sure protection from static sparks.

#### STILL HAVE STATIC SPARKS

The only anesthetic gas explosions known to have killed patients have occurred within the closed circuit of an anesthesia machine. And yet to date no progress has been made toward eliminating static sparks from within the machine itself. Conductive rubber hose and connections might solve the problem. Theoretically the safest method, a proved remedy in war-born rubber factories, would be to ionize the gas within the machine's closed circuit. If this were done, the air itself would become a conductor of static electricity and continually neutralize any potential. Experiments are now in progress on comparatively long lived alpha ray emitters which eventually may lead to the development of an absolutely safe anesthesia machine.

Aside from conductive floors and the other protective measures mentioned, elimination of static sparks is largely an administrative measure. Constant vigilance is the price of safety.

In conclusion, to those who are now faced with enforced installations of explosion-proof operating room lights because of the presently accepted National Fire Protection Association recommendations I suggest referral to the editorial on the subject in the January 1947 *Hospitals*. Because of the present controversial nature of the requirements an appeal to a city corporation counsel or some similar body should in all probability facilitate a delay in decision until the National Fire Protection Association has had an opportunity to act upon the proposed changes in the code.

# And Then Came BLUE CROSS

**FLORENCE KING**
Administrator
Jewish Hospital
St. Louis

ABRAHAM LINCOLN is credited with saying, "All that I am, I owe to my angel mother." It is claimed that the modern child may say, upon reaching adulthood, "All that I am, I owe to spinach and child psychology." May I make so bold as to say that many a hospital of today might well declare, with qualifications of course, "All that I am, I owe to Blue Cross."

Don't misunderstand me. I know that hospitals existed long before the advent of any Blue Cross plan and that if all the plans in the country went out of existence tomorrow there would not be a general closing of hospital doors. But I also know that many of us would experience rather a hollow feeling if we thought that the first of next month the postman would fail to bring us a substantial Blue Cross check.

### WHEN THE DEFICIT SOARED

Having been a member of the hospital ilk for a longer time than any woman can afford to admit, I've known the lean and the fat years. Of late I have found myself all but gloating over bulging receipts, but how indelibly seared on my memory are those despairingly red figures of the depression days, when the cash deficit in my own hospital soared to $119,000, or 55 per cent of the year's receipts! It is true that I've lived to see the day when we have all but borrowed the tourist court's "No Vacancy" sign to hang in front of our building, but well do I recall the less than 50 per cent occupancy figure on our annual report year after year. Bleak days those were for almost all of us.

And then came Blue Cross. How eagerly we threw ourselves heart and soul into its organization. We boasted that we were motivated by a sociological dream and we waxed loquacious on the subject of providing good hospital care for the man of modest means. But no hospital administrator lost sight of the fact that Blue Cross would help fill empty beds and none balked at the thought of blue replacing red ink in the annual report. Indeed, we still find the receipt of the Blue Cross monthly check a refreshing first of the month event and I fear we lavish less and less thought on the sociological angle.

Just what has Blue Cross done for us? During the dismal red ink days we were forever preaching the wisdom of entering the hospital at the slightest provocation. We pleaded with people not to wait until they were seriously ill and reeled off figures to prove that early hospitalization prevented serious illness and shortened its duration. One of our favorite National Hospital Day slogans admonished the public to take as good care of its body as it did of its automobile. We urged the hale and hearty to go into the hospital for a careful checkup and predicted for the sufferer from the mildest cold nothing short of pneumonia and the oxygen tent. Blue Cross at its outset did exactly what we had asked of it—helped provide that early hospitalization which, according to our own preachments, would prevent serious illness and prolonged hospitalization.

Blue Cross sent us satisfied patients who, relieved of worry about the payment for their hospitalization, could relax and more readily respond to hospital care.

It created good will and sympathetic understanding. People who had feared or hated the hospital, because they dreaded the financial drain, came to know and appreciate it.

Blue Cross placed many charity patients in the paying category and spared them the embarrassment of accepting free care. And, while bolstering the pride of the charity patient, it relieved the hospital of the financial burden of providing free care. Just recently the president of my board sat in my office shaking his head over the dearth of free work in our hospital where we have always prided ourselves on the amount of service given the indigent. Scrutiny of that day's census revealed that a majority of the patients whose records showed a previous charity admission were now Blue Cross subscribers. What Blue Cross has done for the pride of those patients, as well as for the hospital till, is, to quote the language of the day, "something out of this world."

Blue Cross filled empty hospital beds and thus enriched not only our coffers but also the teaching service for student nurse and intern.

It guaranteed sure, prompt payment to the hospital and sent the bad debt figure scuttling to a new low.

### PROPHETS WITHOUT HONOR

It made some of the prophets look a little silly—those who had predicted that Blue Cross would pave the way for unnecessary admissions and prolonged hospitalization. We all know that hospital beds have gone to some malingerers who should not have been admitted but the close check kept on all diagnoses by Blue Cross has helped minimize this abuse. An eleven year survey kept in my own hospital has proved that the average length of stay of the Blue Cross patient has invariably been shorter than that of the other patient. Apparently neither physician nor patient has wanted to squander a day's care lest it be required for subsequent illness before the year's allotment has been used.

Blue Cross has compelled hospitals to toe the mark as far as medical records are concerned. Prompt payment was predicated on promptly submitted reports which could not be gleaned from incomplete records. So attending staff and residents have been prodded into completing their medical records more quickly.

Presented at the annual convention of the American Hospital Association, St. Louis, September 1947.

It has goaded us into keeping more orderly financial and accounting records. In those plans that pay a flat rate, it has demonstrated in many instances the superiority of the flat rate over the unpredictable nickel-and-diming system indigenous to many of our hospitals that confuses and annoys both cashier and patient.

It has, oh so very subtly, guarded hospital policy and pricked the conscience of many an administrator. A nurse in another city astonished me recently by saying. "The administrator of my hospital hates Blue Cross patients because he can't gouge them as he does others." In a situation like that, I say "All glory to Blue Cross and its check on charges." By providing standard benefits and not resorting to the artifice of fine print, Blue Cross has enabled the subscriber to keep the faith. He was told what to expect when he subscribed and has not been disillusioned at the cashier's window in the hospital.

#### FINANCIAL LIFE SAVER

Being of Scotch descent, I take joy in dragging out those good, cold figures that are said not to lie to prove that Blue Cross has indeed been a financial life saver for the average hospital. Naturally, I am most familiar with the experience of my own hospital. Ours is a general hospital with a daily patient average in recent years of close to 300. Normally our patient load averaged 25 per cent free, 50 per cent part pay, and only 25 per cent full pay. During the war and since, owing to changing economic conditions, our free load has declined some and the part pay and full pay loads have increased, although the full pay even now amounts to only 27 per cent. We do not charge for the use of radium, for dressings or for any but the most expensive drugs. We operate a free clinic and a school of nursing and maintain a rather large resident staff, all of which necessitate considerable financial outlay. And yet there hasn't been a year in the history of Blue Cross when we did not make a profit over and above cost on Blue Cross patients.

I shan't bore you with a myriad of figures but I shall cite a few to prove that I know whereof I speak.

In 1937, when our plan was in the teething stage, we gave 994 days' care to Blue Cross patients and received for that care an average of $7.59 per patient. During the same year our income from all other patients averaged $4.76 each and our actual cost was $5.62. Therefore, we netted $2.83 per day profit for the 994 days or $2800, and gained $1.97 per day over our actual cost, or a total gain over cost of almost $2000. Three years later, when we received an average of $7.99 per day from Blue Cross patients and gave them 7100 days' care, we received an average of only $4.09 per day from our other patients and our average cost per day was $5.36. That year we received $28,000 more from our Blue Cross patients than we would have had they paid as the others did, and our gain over actual cost on this small group was almost $19,000. Each subsequent year has shown a similar picture, some more dramatic than others, with a constant increase in Blue Cross income which always paid us more per patient day than did our regular source of income.

By 1946 benefits to the subscribers had increased markedly and so had payments to the hospitals from Blue Cross. But in spite of all the increases, our 1946 picture showed that on each Blue Cross patient day we cleared $1.54 over the average income paid by other patients, or a total of $52,000, and our net gain on Blue Cross patients over and above our actual cost per patient was 67 cents per day, or $23,000.

Then came 1947 with hospitals shouting everywhere that they were losing vast sums on Blue Cross patients. A review of the first six months of 1947 in my own hospital reveals that, owing to another increase in payments by Blue Cross, we received an average of $10.73 per day per Blue Cross patient, while the average income from all our other patients was $8.70 per day and our actual cost rose to $9.90. So you see that we netted a gain of $2.03 per Blue Cross patient over the amount paid by others, or a sum of $43,000 for the first six months of 1947, while our gain over our actual cost per day was 83 cents, or $17,500.

Since I gathered these figures, the payment by the St. Louis plan to our hospitals has been further increased but the new arrangement has not been in effect long enough to produce statistics of any value.

I have ignored billed charges because they show only an artificial picture. To my notion, using *actual income* and *cost* for comparison gives the true picture.

At the risk of boring you with too much Jewish Hospital financial lore, I have tried to show from a dollars and cents angle what Blue Cross has done for an average hospital which has, even in this year of our Lord 1947, greatly benefited financially and otherwise from its participation in the Blue Cross program.

We at our hospital like Blue Cross. For us it symbolizes the fabled rich uncle who dug into his pockets to help us generously when we were almost literally drowning in a sea of red ink. If he can't shell out quite as much over and above our needs at present, we'd be an ungrateful lot if we complained. He might be tempted to ask us what we did with all he showered upon us back in those days when, had we been good bookkeepers, we would have set up a reserve fund with the Blue Cross surplus.

It is surprising to note the number of grumbling hospital administrators who complain that Blue Cross doesn't even pay their cost. They speak only of the amount paid by Blue Cross and conveniently ignore the large percentage paid by the average patient for those ever mounting "extras." Nor do they mention the years during which they rolled up a tidy surplus in the Blue Cross column.

#### THE DAY MAY COME

The lush postwar days with their inflated cash receipts have given some of us the big head. While no one wants another depression, the newspapers and our own common sense predict some slackening in today's prosperity, so there may come a day when our present high and mighty attitude toward Blue Cross will make us feel a wee bit sheepish. It ill behooves any of us to be too opulent lest we find ourselves eating humble pie one of these days at the hand of our former benefactor, Blue Cross.

How completely many of us have lost sight of the sociological factor of Blue Cross. In those early depression days we talked loud and long of the benefits that would accrue to the poor working man and his family. In a short ten years that poor man and his family have been almost lost in a maze of dollar signs. Let's interest ourselves again in the patient and acknowledge our debt of gratitude to Blue Cross which has given us the wherewithal to provide that poor working man with good hospital care.

Let's acknowledge our debt of

gratitude also for the many other ways in which Blue Cross has aided us. Through the years it has so insinuated itself into the very core and fiber of our hospital life that we scarcely think of it as a separate institution. No matter what confronts the hospital group, be it street car strike, hospital convention or a publicity stunt, Blue Cross willingly lends a hand. Here in St. Louis several of the hospitals have not joined the hospital council, but all are participants in the Blue Cross program. So Blue Cross has become the common denominator for all our hospitals.

All in all, we hospitals won't be guilty of too gross exaggeration if we borrow and paraphrase Mr. Lincoln's words and say, "Much of what we are, we owe to Blue Cross."

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# Public Responsibility for Care of the Indigent

**F. STANLEY HOWE**
Director
Orange Memorial Hospital
Orange, N. J.

WHERE voluntary hospitals have been created and maintained at private expense, either in place of public hospitals or to supplement them, the voluntary hospital assumes all the financial obligations of a public hospital and is expected to provide every known service and facility. In return for this service these hospitals should not be expected to incur any losses on the work they are doing for patients who are unable to pay all or any part of the cost. To the extent that such patients do not pay the full cost and when funds raised in their behalf by Community Chests or as income from endowment funds are not in themselves sufficient, the unmet portion of this expense should be assumed by the public through the mechanism of funds raised by taxation of the whole population based upon each person's ability to pay.

Failure to do this places the voluntary hospitals in the position of a tax collector who is limited in the collection of these charges to two small classes of "taxpayers," namely, the handful of individuals who are patients in the hospital, and at a time when they are least able to incur extra expenses, and, second, the hospital employes, without whose effort and skill there would be no hospital service at all.

The gradual reduction in income from endowment funds and from community chests and the rapid increase in the cost of everything required by the hospitals have widened the gap between income and expense to a degree which can no longer be bridged by the limited power of the hospital to assess its patients and employes.

It consequently becomes necessary to go back to government with the demand that it make provision for reimbursing the voluntary hospitals for all losses shown to have been incurred in the care of the medically indigent whether or not such patients are technically eligible for municipal assistance. The one deciding factor is the balance between the cost of serving this group and the funds available to cover this cost.

In other words, government should make the same provision for meeting all deficits shown to have been incurred by voluntary charitable hospitals on the medically indigent as would be done routinely had this service been given in a hospital maintained at public expense.

Proof of this is to be found in the increasing number of areas in which radical increases in such payments have been made. In November the state of Maryland enacted legislation establishing a maximum rate of $10 a day where costs can be shown to have equaled or exceeded this amount.

In New York City 49 voluntary hospitals have recently offered to place at the disposal of the city several thousand ward beds that are badly needed for indigents, provided the city will reimburse them at the rate of $12 a day.

In Rhode Island the leading hospital in Providence, following a series of publicity releases outlining the financial problem of the hospital, has demanded a rate of $10 as the least for which it can continue to care for indigents.

Other communities have seen the wisdom, as well as the necessity, of treating fairly voluntary hospitals that are doing the public's work. More will inevitably do the same as soon as their citizens have been aroused to the fact that hospitals, like everything else, must meet the increase in cost of both commodities and service but may be forced to close their facilities unless relieved of the growing drain upon their financial resources.

The voluntary hospitals of the United States represent an investment of several billions of dollars and their annual support, which has come almost exclusively from private sources, has been an immeasurable contribution to the welfare of the people. Failure of the hospitals to survive because of increasing deficits will be a great loss to the public in quality of service and will force the taking over of these facilities by government. Such a result will undoubtedly cost the public more in the end than would the continuation of such hospitals under private control.

The appropriations of the cities for hospital care represent but a minute fraction of their total administrative budgets so that doubling such appropriations in the average municipal budget would have a negligible effect upon the tax rate. The cost of all other municipal functions is rising rapidly and for the same reasons that govern the increased cost of hospital care.

No considerations either of public policy or of financial limitations can justify the refusal of any municipality to protect the voluntary hospitals against any losses incurred for the care of its indigent sick.

# MINIMUM STANDARDS for Chronic Disease Hospitals

## of 150 Beds and Over

AN ORGANIZED medical staff of competent ethical physicians for the efficient care of patients and for carrying out the professional policies of the hospital, subject to approval of the governing board, is just as necessary in the chronic disease hospital as it is in other medical institutions.

However, certain differences exist which already have been pointed out, namely, the preponderance of clinical responsibility falls on a limited number of mature staff physicians, who customarily are housed on the premises. These men should be well qualified professionally. In addition, a visiting or consulting staff should be available for consultation in the medical specialties. Committees of the medical staff can be organized to promulgate high standards of professional work, or this responsibility may fall largely on a clinical or medical director.

### FIVE RESIDENT PHYSICIANS

We have five mature physicians living on the premises and assuming the bulk of responsibility for the medical care of the patients. These physicians are under the jurisdiction of a medical or clinical director and meet weekly to review the professional work of the hospital. A committee of two arranges the program for staff conferences. The clinical director is responsible for seeing that proper medical records are maintained. A large group of distinguished consultants, who also are staff members of St. Luke's Hospital, is available for consultation in the specialties and makes frequent visits to the institution as required.

In any event it is necessary that the medical staff be well organized and it is recommended that the following divisions of the medical staff be established: (1) honorary, (2) consulting, (3) active attending, (4) resident and (5) courtesy.

The honorary medical staff should comprise physicians not necessarily active in the hospital but who are honored by emeritus positions. The consulting medical staff should consist of recognized specialists who are active in the hospital or who have signified willingness to accept such appointment. The active attending medical staff should consist of physicians who are both willing and able to devote their interests and time to the hospital. Members of the active attending medical staff should not be required to be exclusive specialists in the particular branch of medicine to which they are assigned, but a large proportion of their practice should fall within such specialty.

The resident medical staff may be divided into two divisions: senior members and junior members. The senior members may be considered an integral part of the active attending medical staff but in residence at the hospital. The junior members are those physicians appointed to the staff for residency training purposes or they may be members of the intern staff. The courtesy medical staff should comprise members of the medical profession permitted to attend private patients in the hospital but who do not desire to become members of the active attending medical staff.

Regular medical staff meetings should be held, as should clinical pathological conferences, at frequent intervals to review the professional work of the hospital. Active attending medical staff members, as well as the senior division of the resident staff, should be requested to attend all medical staff meetings. Other divisions of the medical staff, that is, honorary, consulting, junior resident and courtesy, may be invited but not required to attend the clinical conferences and other regular medical staff meetings.

The opportunity for establishment of many clinical departments is provided by the well organized chronic disease hospital. These may comprise the following:

1. Medicine
2. Neurology
3. Cancer
4. Surgery and orthopedics
5. Urology
6. Otolaryngology and rhinology
7. Ophthalmology
8. Gynecology
9. Dermatology
10. Radiology
11. Pathology and clinical laboratories
12. Physical therapy, occupational therapy and recreational therapy
13. Dentistry and oral surgery
14. Anesthesia
15. Pharmacy

Other services may be established from time to time as determined by the medical staff and the board of managers in the light of specialization and medical and patient needs of the hospital.

In addition to the opportunity for an intern program, established independently or in affiliation with a general hospital, there is wide possibility for the establishment of various residencies as follows:

1. Cardiology
2. Malignant diseases
3. Medicine
4. "Mixed" residency
5. Neurology
6. Pathology
7. Physical therapy
8. Radiology

These residencies may be established independently or in affiliation with a general hospital.

Our medical staff appointments are made in the customary manner. Formal application is made, with endorsement of the medical director and the superintendent. Approval by the executive committee follows, with appointment finally by the board of managers.

From an organizational standpoint the entire medical staff, including resident staff physicians, attending men and consultants, is responsible through the medical director and the superintendent to the board of managers for the satisfactory performance of professional work.

The professional policies of the hospital, as well as the by-laws, rules

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St. Barnabas Hospital
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and regulations of the medical staff, should be in written form and subject to the approval of the governing body, as are the staff appointments themselves.

It is necessary that adequate diagnostic and therapeutic facilities exist in the chronic disease hospital, with efficient technical service under competent medical supervision. This is no less important for proper care of long term patients than it is for acutely ill patients.

While the number of patient days of service ordinarily is high in chronic disease hospitals, the turnover of patients is low. For example, in the 350 beds of our hospital section during 1945 there were rendered 127,188 hospital days of service. This represents 271 patient admissions, 65 employe, and 67 Braker Home admissions, totaling 403. This peculiarity of patient care, characteristic of chronic disease hospitals, may not require the highly developed adjunct diagnostic and therapeutic departments to the same extent as prevails in general hospitals. However, it should be stressed that adequate professional departments are essential, which may be enumerated as follows:

1. X-ray department, both diagnostic and therapeutic.
2. Clinical and pathological laboratories.
3. Necropsy and morgue service.
4. Dental service.
5. Laboratories for electrocardiograms and basal metabolic studies.
6. Physical therapy department.
7. Occupational therapy department.
8. Recreational and rehabilitation program.
9. Pharmacy service.
10. Oxygen therapy service.
11. Dietary therapeutics.
12. Operating room service.
13. Medical library.
14. Clinic or outpatient department.
15. Eye, ear, nose and throat departments, as well as facilities for other required specialties.
16. Adequate facilities for treatment of fractures and other orthopedic conditions.
17. Other services as warranted by medical needs and scientific developments.

Every adjunct medical service should be headed by a competent medical specialist, a diplomate of an American board or other accrediting body. These professional chiefs may serve on a part time or full time basis, depending upon the exigencies of the situation with respect to each department. The various technicians should be certified by their respective professional bodies as to competence.

For example, at St. Barnabas Hospital for Chronic Diseases more than 4000 physical therapy treatments are rendered monthly and the physician-director visits the institution two or three times a week. Under the director are three full time paid technicians and eight student technicians.

Similarly, the radiologist visits the institution two or three days a week; the pathologist, who is always on call for necropsies, also visits regularly two or three times weekly. Moreover, a visiting dentist makes regular calls to the institution several times a week to care for dental problems. As a minimum there should be one dentist on the staff, but it is desirable that a well organized department exist, with a dental chair and part time or full time dental care.

Finally, emphasis should be placed on the opportunity for research and educational functions in the chronic disease hospital. The variety of diseases prevalent, particularly in a far advanced form, represents a wealth of material of value in medical teaching. With the increased aging of the population, emphasis on chronic diseases is ever more significant.

The United States Public Health Service has determined that there are 23,000,000 Americans currently struck down with chronic disorders which disable them wholly or partially over long periods of time. Half of the victims of chronic disease are under 45, and one in every six, under 25. Medical science must of necessity give increasing emphasis to the problems of degenerative and chronic diseases, inasmuch as these represent today the greatest challenge in the field of public health. It is in the laboratories of chronic disease hospitals that opportunity exists to discover answers to many perplexing problems of chronic illness.

## MEDICAL RECORDS

It is especially important that accurate and complete medical records be kept in the chronic disease hospital, promptly written and filed in an accessible place so as to be available for study, reference, follow-up and research.

In our institution the medical records are kept in chart racks centralized at the nurses' station on each floor. These racks are mobile and can be moved with facility. Medical records in the chronic disease institution may assume large bulk, as patients are kept over a prolonged period. On the other hand, it is not necessary that notes be made as often for the chronic disease patient as for the acutely ill and, therefore, the bulk of the record is slower to develop than is the case in the general hospital.

A well organized medical record department under a competent medical record librarian is required. We employ one medical record librarian, who is able to handle competently the number of records at this hospital. In smaller institutions, that is, those between 100 to 200 beds, the medical record librarian may serve on a part time basis, but in a full time capacity, the other half of her time being spent as a medical secretary or admitting officer.

Basically, the differences are not marked, in our experience, between problems of medical records in a chronic disease as opposed to a general hospital, except for the question of duration of stay of patients. This latter feature, however, has not presented a serious problem.

The medical history and physical examination should be written within twenty-four hours after admission and notes should be kept promptly up to date, as is customary in well run institutions. The Standard Nomenclature should be used and a disease index should be maintained, as should indexes for patients, operations, necropsies, physicians and end results. Nurses' records may be modified somewhat so that they do not assume undue bulk. For example, temperature charting is not necessary at frequent intervals on patients who are not in an active stage of disease.

Group conferences of the adminis-

trative staff and the medical staff are as necessary in the chronic disease hospital as in the general hospital to review regularly and thoroughly their respective activities in order to keep the service and the scientific work on the highest plane of efficiency.

At this institution weekly medical staff meetings and monthly clinicopathological conferences are held to review the professional work of the hospital. In addition, the medical director, business manager, superintendent of nurses and social worker, and other department heads as required, meet daily with the administrator. During winter months larger departmental conferences also are held at semimonthly intervals for education, informative and other purposes.

These three types of conferences are invaluable for proper administrative coordination of the various departments and services in the chronic disease hospital. The chronic disease institution does not differ in any respect from the general hospital in the necessity for these coordinative efforts.

This is the third in a series of articles on minimum standards for chronic disease hospitals. Another article will appear next month.—ED.

## Economy Is Self Evident in a

# Central Ambulance Service

**ALEXANDER BERESNIAKOFF**
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THE ambulance is an important adjunct to a general hospital; therefore in planning a hospital proper provision must be made to house this service. A separate structure or adequate space within the hospital must be provided to accommodate about four ambulances, a repair shop, gasoline storage tanks and pumps, accommodations for the crews who drive the ambulances and an office for the administrator of the ambulance service. All this means space (of which there is never too much in most hospitals) and considerable cost. Considerable space and cost, however, could be saved by a centralized ambulance garage.

### FOUR HOSPITALS, FOUR GARAGES

Cities like New York, Chicago, Detroit, Boston and others which have numerous city owned and operated hospitals are particularly adaptable to the idea of the centralized ambulance garage. Taking only one of the boroughs in New York City as an example will illustrate the advantages and savings which could be effected from the centralized ambulance garage.

In the borough of Manhattan there are at present, or in the planning stage, four general hospitals: Bellevue, Harlem, Metropolitan and Gouverneur. Each of them either has or is to be provided with an ambulance garage and all requirements for its operation and administration. This will be repeated four separate times: four separate allocations of space, four separate crews of personnel (drivers, mechanics, administrators), four separate places for the delivery and the storage of gasoline and oil, whereas, *one ambulance garage centrally located* could serve all of these hospitals at a great saving in cost and space and with greater efficiency.

Figuring conservatively, four ambulances are required to serve a general hospital; therefore, 16 ambulances would be needed to serve the institutions mentioned. In a central garage this number could be reduced to 12 or even 10 and still provide adequate ambulance service, thus effecting a saving of between 25 and 33 per cent. The ambulance repair shops from a total of four required at present could be reduced to one in a central garage, with facilities for repairing two vehicles at one time, thus effecting a saving of 50 per cent or better in space and equipment. The offices for the administration of the ambulance garages, from a total of four required at present, could in a central garage be reduced to one, with facilities for one administrator and, perhaps, one assistant.

This saving of space and facilities would also apply to those required for the accommodation of the doctors on ambulance service. Only one room for doctors and only one kit preparation room would be necessary and there would also be a saving in the number of doctors required on service in a central garage.

The economies in the savings of space, machines, equipment and furnishings so far indicated in the idea of a central ambulance garage, as compared with an ambulance garage attached to each institution, should be self evident to those who hold the purse strings for the building, administration and maintenance of municipally owned hospitals.

This idea of a central ambulance garage could be applied to every district or borough of large cities with several hospitals serving large sections of their population, and also to small cities having several hospitals serving their entire population.

### POSSIBLE LOSS OF TIME

The question might be raised as to the possibility of loss of time in an ambulance's reaching a distant point. In answer to this, the borough of Manhattan, with its four general acute hospitals, can be cited again. Harlem Hospital is located at 137th Street; the proposed Metropolitan Hospital will be located between 97th and 99th Streets; Bellevue Hospital is at 26th Street, and the Gouverneur Hospital is at Gouverneur Street (approximately First Street). Therefore, an ambulance garage centrally located somewhere between Metropolitan and Bellevue hospitals could serve the two remote hospitals speedily—more speedily, perhaps, than under the decentralized system, because there would always be ambulances and doctors available to answer the calls, which is often not the case under the present system, and time is lost by the necessity of relaying calls to other hospitals. Such hospitals are not necessarily close to the section the ambulance is supposed to reach.

Another point might be raised as to the doctors on service under the central ambulance plan. Wouldn't the services which they might perform within the hospitals between calls be lost to the institutions? Such service would not be lost for the idea behind this plan is that there should not be much idling time between calls. Therefore, there will be practically no time between calls for the doctors to perform any other services.

# PLAN FOR PROVIDING NURSING CARE

## Has This One Advantage

## IT WOULD WORK

**THOMAS HALE Jr., M.D.**
Director, Albany Hospital, Albany, N. Y.

HOSPITALS should not assume responsibilities which they are not properly equipped to carry out and, furthermore, when a hospital *does* recognize its responsibilities in a given field, it must *demand and be given* the authority and control necessary to fulfill this responsibility properly.

There is one responsibility which is fundamental to all hospitals everywhere, *i.e.* the responsibility for proper nursing care to patients. A hospital cannot escape this responsibility once it opens its doors and admits a patient. It cannot share or assign this responsibility nor can anyone else assume it.

### WHAT IS THE CAUSE?

Why are hospitals finding themselves unable to give adequate nursing care to their patients at the present time? What is the reason? Is there a single cause, or are there many causes, leading to this result? These are questions which today are troubling not only hospital administrators but also the nursing profession, the medical profession, state and federal public health agencies, and members of the legislatures of both the state and national governments.

Nursing care to patients in Albany Hospital, Albany, N.Y., up until a year or so ago, was supplied by general staff nurses, practical nurses and student nurses in varying proportions. There was also a group of ward helpers called "aides" who gave no personal care to patients but fitted in somewhere between the housekeeping maids and the nursing groups. Floor clerks have helped take over a large share of the clerical duties, but we are not concerned with them here. Practical nurses are not permitted to give medications or treatments, but with this exception they have been freely used everywhere in the hospital for twelve years.

About two years ago it became quite apparent that with the ending of the cadet nurse program, and with the increasing difficulty in hiring general staff nurses and practical nurses, it would be impossible to continue to run the hospital unless we supplemented our nursing staff in some way. With this thought in mind, therefore, we organized in the early months of 1946 a program for training individuals to help nurses with the bedside care of patients, and we called these individuals "nurse attendants." We gave them four weeks' training, at the end of which time they were assigned to various nursing locations, and they have worked under the supervision of the general staff nurses and the nurses in charge of the wards.

The course of training corresponds fairly closely to the program for training Red Cross aides set up by the Red Cross during the war. During their training period attendants work 48 hours a week, 38 of which are practice and 10 of which are spent in the classroom. Thereafter, they work 40 hours a week like all other employes.

We have no age limit on our nurse attendants, but we have found that in many cases some of the older individuals have not been able to stand eight hours a day. This has been one of our most difficult problems. We have maintained our nurse attendant group at an average of 75 people, but it has been our experience that the turnover is much greater than in our general staff nurse and practical nurse groups. I am sure that a major proportion of this can be attributed to weak feet and to nothing else. Most of the women seek this work because they like it, and their morale has been good right from the start. We have assigned a general staff nurse full time to the teaching and supervision of these attendants.

At the beginning of this program we paid nurse attendants at the rate of $100 a month for the first three weeks of training, and $110 a month at the completion of this period. Since that time we have found it necessary to increase the starting salary twice so that we are now starting them at $120 and raising them to $130 at the conclusion of the training period. They can earn as much as $140 a month and could at first increase whatever they earned by a $10 a month bonus if they worked an evening or night shift. Some months ago we were able to abolish this $10 bonus because a sufficient number of nurse attendants *preferred* to work the evening or night shift. (We still pay general staff nurses and practical nurses such a bonus.)

### ADDS ONE MORE GROUP

One of the few disadvantages we have encountered in adopting this new classification of workers is that it adds one more group to the already too numerous categories of workers on the floors. We now have general staff nurses, practical nurses, nurse attendants, nurse's aides and housekeeping maids. The maids have always been members of the housekeeping department, but we decided to abolish this category entirely, increase the number of nurse's aides, and have the aides

Condensed from a paper presented at the New York State Hospital Association meeting, May 1947.

take over the housekeeping activities on the floors, bringing these functions under the direct supervision and control of the nursing department.

As the practical nurses and nurse attendants carry out approximately the same duties and activities, it is quite likely that we will eliminate one or the other of these two groups eventually, although there has been considerable discussion as to whether we should abolish the practical nurses and use nurse attendants only, or abolish the nurse attendants and use practical nurses only. The latter proposal is out of the question at this time because there are not enough practical nurses available. It would also be more expensive.

How should hospitals plan in the future to nurse their patients? Is it possible for them to ensure that there will be enough nurses to give the necessary nursing care? Have they any control over this important factor? Should they turn to the nursing profession and say, "You guarantee to us and to the public that there will be enough nurses to care for the sick, both inside and outside of hospitals"? Or should hospitals recognize a responsibility of their own in this matter, separate from that of the nursing profession?

## LET'S FIX RESPONSIBILITY

It seems to me that an agreement should be reached between the hospitals and the nursing profession as to where this responsibility lies. If the nursing profession wants to assume it, then the hospitals and public must be able to look to the nursing profession for an integrated program that will ensure enough recruits to take care of the full nursing needs of the public at a cost which the public can assume. If the nursing profession does not wish to assume this responsibility, then the hospitals must assume it and in this event they will have to adopt an integrated program that will produce the necessary number of nurses.

By an integrated program I mean one that is broad enough to include the recruitment, training and licensing, in those cases where licensing is desirable, of enough individuals to supply adequate nursing care to the public, both within and without hospitals, at a cost which will not be too burdensome. Such a program would have to be accepted by the hospitals, by the nursing profession and by the state.

It is quite probable that there is

more than one program that would work, and there have certainly been many suggestions made by various outstanding individuals in the past few months, but no one seems to be taking the initiative in putting into effect any one of these suggested programs. In the meantime, the *nursing of patients*, which after all is the primary responsibility of the hospital and the only reason for the existence of the nursing profession, is simply not being taken care of.

What *is* the function of a "nurse"? What was it in the past and what should it be in the future? Should not the terms "nurse" and "nursing" be reexamined and redefined in the light of changing conditions? Are we not confused because different people mean different things when they use these terms?

The responsibilities of the nursing department on the floors of the hospital can be roughly divided into three main functions. The first of these is bedside care of patients; the second is the giving of treatments and medications, and the third is the general supervision of the ward, including the teaching and supervision of students.

I have within the last year heard leaders of the nursing profession deplore the fact that because the giving of treatments and medications and the general supervision of the wards took up so much of their time, nurses no longer had time to give beside care to patients, *the real function of a nurse*. I have heard other leaders of the nursing profession deplore the fact that because the bedside care of patients and the general supervision of the wards took up so much time nurses no longer had adequate time to give treatments and medications, *the real function of a nurse*. I have heard still other leaders of the nursing profession deplore the fact that because bedside care and the giving of treatments and medications took up so much of the time nurses no longer had time properly to supervise the running of the ward, *the real function of a nurse*.

I do not pretend to know what the real function of a nurse is. I think that is a question which only the nurses themselves can answer. The question I would like to raise is: has not hospital nursing become so complicated as a result of new methods and modern scientific procedures that the functions the nurse formerly fulfilled in a ward have become too detailed, too complicated and too time consuming for any one person to handle?

It is perfectly obvious that in order to supervise and run a hospital ward today, a nurse with a high degree of training and intelligence is required. But does it follow that the same high degree of education and training is needed to give adequate bedside care to patients, or to give medications and treatments, or to do technical assisting in such locations as the operating and central supply rooms?

## GIVE GOOD BEDSIDE CARE

At Albany Hospital we have found that nurse attendants working under the supervision of highly trained nurses can give *good* bedside care to patients. These attendants can be recruited by the hospital in whatever numbers they are needed, at a wage level which will not be an undue burden on the paying patients, and the hospital retains control of its ability to give nursing care at this level. The last war proved that untrained people could be taught in a relatively short time to carry out many activities formerly thought to be integral parts of the nurses' training.

However, the nurses who supervise wards, operating rooms and other special locations; the nurses who teach students, practical nurses and technicians, must obviously be thoroughly and intensively trained. I would not quarrel with those who feel that these individuals should have a college degree, although I do not believe it should ever be a prerequisite to licensure as an R.N. I seriously question, however, whether it is necessary or desirable to require such high standards and such expensive and time consuming preparation, with the resultant necessity for higher wages, for those individuals who give bedside care to patients in the hospital or in the home and carry out technical and mechanical procedures in the hospital.

Let us suppose that in the future we restricted the term "registered nurse" to those individuals, of whom

there would be a relatively small number, who were graduates of schools of nursing affiliated with teaching hospitals. These individuals would be licensed by the state and their training and education would be under the supervision of state departments of nursing education. These schools might or might not be "collegiate schools" of nursing. By a collegiate school I mean one in which a girl obtains two years of college credit either before or after she takes her three year hospital nursing course, at the end of which time she is eligible for a degree.

Let us next suppose that all nonteaching hospitals train practical nurses and/or nurse attendants. The practical nurse course might be twelve months or less in duration and these individuals might also be licensed by the state, which would mean that the state could enforce certain standards of training.

Finally, let us suppose that *any* hospital could train a so-called nurse attendant and give as many weeks or months of training as it desired. These attendants would not be licensed by the state but would simply constitute auxiliary aides to the registered and practical nurses in their work.

If such a program were adopted it would mean that a number of hospitals would be training practical nurses and/or nurse attendants when they would prefer to be training registered nurses. It would mean that the nursing profession would have to accept the growth and development of a large group of practical nurses. It would mean that some leaders of nursing education would have to be willing to limit their ambitions for a college education for *every* nurse to a relatively small group of highly trained individuals. It would mean that the state would restrict its licensing requirements to registered nurses and practical nurses.

All groups involved would, therefore, have to be willing to accept some compromises if such a program were adopted. These might be listed as items on the debit side of the ledger. What items might be found on the credit side of the ledger in such a program? There is only one item on the credit side, but it seems to me it is quite persuasive—*it would work,* and it would supply an adequate number of nurses for the country's needs at a reasonable cost, beginning almost immediately.

## THERMOMETERS AND CROSS INFECTION

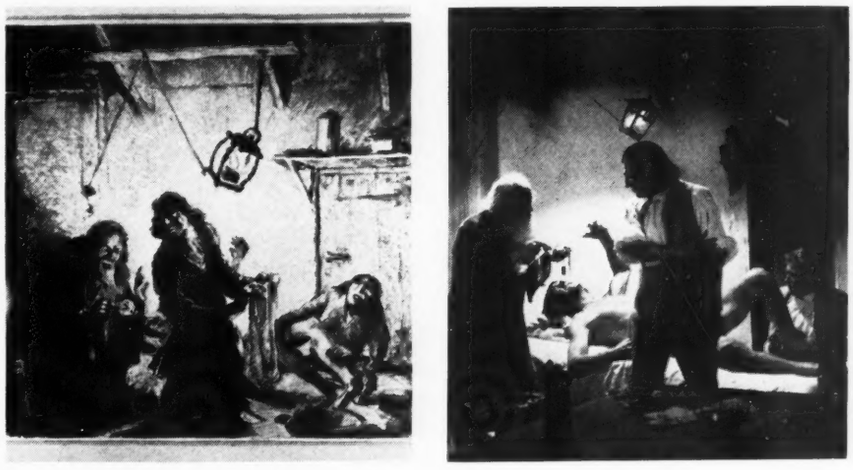
Two English authors, J. B. M. Green and J. B. Penfold, suggest in the *Lancet* (London, England), July 19, 1947, that the friendly nurse, in her temperature-taking rounds about a hospital ward, may be unwittingly introducing a large dose of various pathogenic and nonpathogenic bacteria into the mouths of the patients. The usual technics involve the use of five or six thermometers for from 20 to 30 patients. Temperatures are taken in batches limited by the number of thermometers available. After each use a thermometer is dipped into a bowl of water and replaced in a jar of antiseptic (in the United States it is more usual to swab the thermometer with an alcohol sponge and place in the solution). The procedure is then repeated. The thermometer remains in the solution for a matter of seconds between patients.

Spot samples of the sterilizing fluids taken without warning while temperature rounds were in progress on all wards of the Essex County Hospital in Colchester, England, were cultured, counted and identified by accepted bacteriologic technics. When the fluid in use was glycerinium thymol compound, the bacterial count varied from 900,000 to 40,000,000 per cc. When equal parts of glycerinium and 1/20 phenol were used, the count was 45 organisms per cc. and when 1/20 phenol alone was used it was sterile. The organisms found were identified as Streptococcus viridans, nonhemolytic streptococcus, B. coli aerogens, Friedländer's bacillus, a vibriorganism, staphylococcus and two types of undistinguished gram negative organisms.

The authors also investigated the bactericidal powers of glycerinium compound against Str. pyogenes, Str. hemolyticus and B. coli and found that in the usual time allowed for sterilizing thermometers between patients (when each patient was not issued a personal thermometer) there was very little action with this solution.

Because more powerful antiseptics (phenol, alcohol, carbolic, perchloride of mercury) are often harmful to the oral mucosa, too noxious to the patient or too expensive, there is a tendency to rely on the weaker antiseptics. The authors suggest that each patient be supplied with a personal thermometer left by the bedside which, after the patient leaves, should be washed and sterilized with a strong antiseptic for a long enough time to allow the solution to act.—E. D. ROSENFELD, M.D.

## Great Moments in Surgical History



**Left: Photographer Lejaren Hiller prepared this sketch of an operation for the Davis and Geck series of pictures depicting "great moments" in surgical history. Right: The finished photograph of the historic achievement of Mr. Cheselden in performing a lithotomy with a spectacular new technic in an age when anesthesia was still unknown.**

# HOSPITALS AND UNION IN HARMONY

**ARTHUR HARE**
Secretary
Hospital and
Institutional Workers Union
Local 250
San Francisco

The agreement the hospitals have with the union calls for maintenance of membership and preferential hiring, which to all intents and purposes amounts to a union shop. There is no pay roll deduction for dues, and the hospitals are obligated to call the union for replacements whenever there is a vacancy in categories covered by the agreement. Should the union be unable to supply help, the hospital may hire whomever it pleases, with the understanding that should the individual hired not join the union prior to the time "an acceptable" individual can be supplied by the union, the incumbent shall be relieved of his duties when the new individual arrives for assignment to the job. I say "acceptable" because the individual must meet with the approval of the hospital.

I have checked with various members of the hospital fraternity in San Francisco and they feel that the agreement that they have with the Hospital and Institutional Workers Union, while not all that they might wish it to be, is working quite well.—G. OTIS WHITECOTTON, M.D., *medical director, Alameda County Institutions, Oakland, Calif.*

A TELEPHONE rings. An efficient young woman, with several years' experience in practical hospital operation, takes the call from the personnel department of one of San Francisco's largest hospitals. "An orderly and a kitchen helper? Just a moment. Yes, we can send applicants for both those positions. I'll have them there in the morning. Let me know how they meet your needs."

A few minutes later a middle aged woman walks down the hall to the counter. Her appearance and attire suggest one who has not had things easy, who knows the meaning of hard work.

"A laundry job? Yes, we get calls from the hospitals frequently. Nothing in at the moment, but I know that X Hospital will need an ironer in a few days. Here is our agreement which shows the wage rates and the working conditions. Fill out this card and I'll call you Thursday."

An observer of such activities would be viewing one part of the many affairs going on in the bustling office of Hospital and Institutional Workers Union Local 250 of San Francisco, an affiliate of the Building Service Employes International Union. This local union, which has been active since 1932, represents more than 2000 nonprofessional workers in San Francisco hospitals.

### UNION SHOP AGREEMENT

Local 250 has a union shop agreement with the San Francisco Hospital Conference, an association representing the voluntary hospitals of the city, which covers employes in the housekeeping, dietary, laundry and nursing departments, with the exception of the nurses and technicians. In addition, the union represents workers in the vast City and County Hospital and appears on their behalf before the city officials.

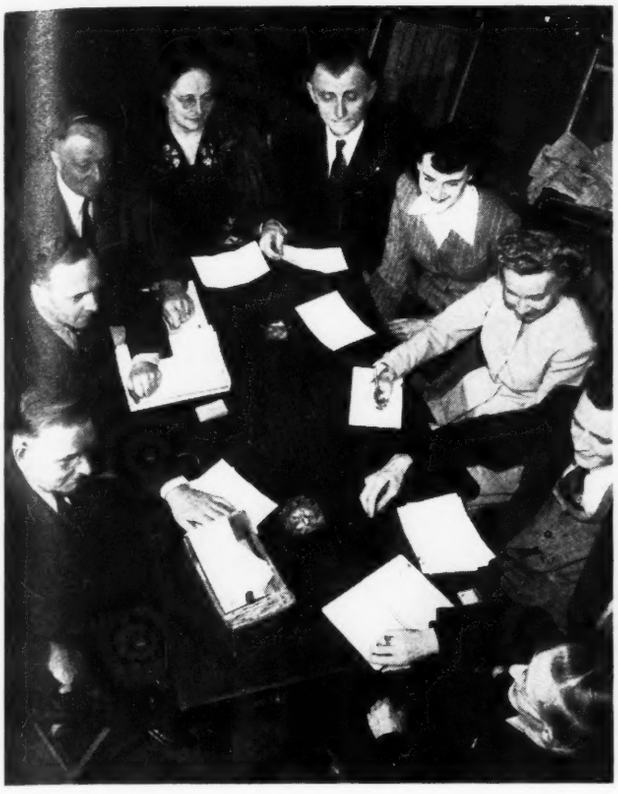
Today, Local 250 is a recognized institution in the hospital field. It was not always so. The story of the union's growth includes chapters of struggle, bitterness and hostility. The first efforts of hospital workers to organize were not immediately successful. Looking back over the last fifteen years, certain lessons emerge which should be of interest to hospital administrators who as yet have not dealt with union labor.

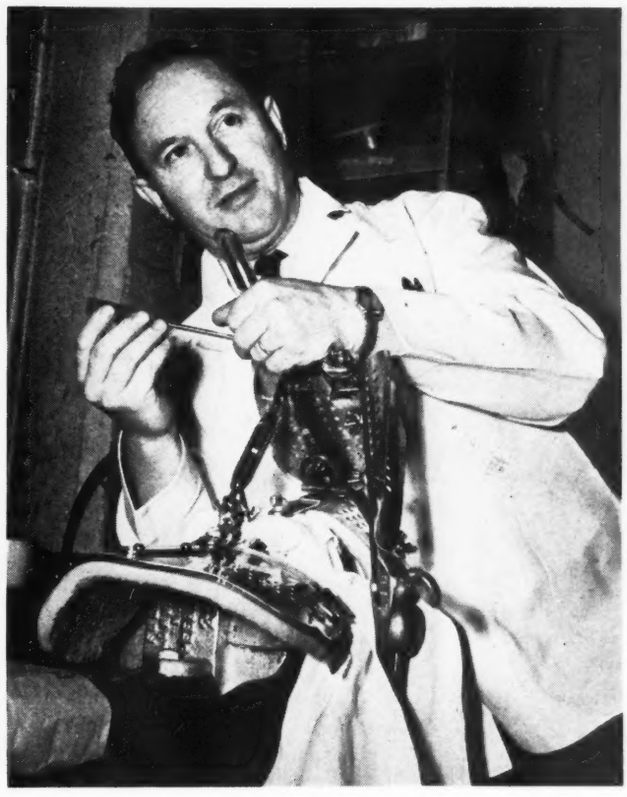
Two factors were of major significance in accounting for Local 250's birth. First, hospital workers at that time were a poorly paid, overworked lot. Second, San Francisco was a strong union town. The existence of a substandard group in the midst of active unionists was a natural. The proper leadership which developed from the ranks of the hospital workers was sufficient to weld those ranks into a united front, determined to improve their status.

In recent years the same pattern seems to be shaping up in other communities. Related unions in private industry are holding out a helping hand to unorganized hospital workers. They know that little islands of substandard workers cannot forever remain isolated from the mainstream of organized labor.

The first efforts of Local 250 to gain recognition from the hospital employers were met with strong resistance. It was several years before a contract was signed. The general line of opposition was: "We are different from other employers. We are not in business to make a profit. Ours is a service of mercy. Our employes do not need a union. They should be happy to serve the sick."

The answer of the union to this position has been most lucidly ex-





**Left: Shop stewards for Local 250 in the voluntary hospitals of San Francisco during the discussion prior to signing the contract recently negotiated with the Hospital Conference of San Francisco. Right: Gene Mittnacht, member of Local 250 and employe of Mount Zion Hospital for twenty-two years, making an adjustment on a brace.**

pressed by Justice Pecora of the New York State Supreme Court, who stated in 1945:

"If a charitable institution is an outstanding public servant and benefactor so, too, is its lowliest employe, whose health should also be preserved and guarded in the first instance by a suitable wage scale. No institution in our form of government should be altruistic, yet niggardly. It may well be that their shining lights of benefaction, mercy and charity, irradiating far and wide, should at least be reflected to the basement of their own structure, and their magnanimity extended even to the lowliest within their walls." (17 Lab. Rel. Rep. 592.)

The primary aim of Local 250 has been to improve the economic well-being of its membership. To the extent that we have been successful, we of the union feel that we have also benefited the hospital management and, thus, the general public.

*Individual hospitals work together on personnel policy.* The advent of the union brought the various institutions together. Of necessity, they act as a team.

*Labor costs are certain for a fixed period.* A union contract sets wage rates, holiday and vacation policy and other matters affecting labor costs. Better planning can be undertaken when one important cost factor becomes certain.

*A new and effective source of labor supply is available.* The union office acts as a clearing house for workers with experience in the hospital field. Trained persons are available to hospitals without the need for advertising and individual solicitation.

*Disputes and grievances are handled sensibly.* The union contract provides for an orderly and peaceful adjudication of any differences that may arise. This means better employer-employe relations and fewer time consuming squabbles that would otherwise vex an administrator.

One fear apparently in the minds of some hospital heads is: "But if my employes join a union, they will go on strike!"

This attitude, in our opinion, is based on ignorance. Local 250 has had no strike in its history and does not intend to have one. Our contract with the hospitals specifically warrants that there shall be no strikes or lockouts. We feel that, contrary to the notion of some employers, work stoppages are more probable in hospitals where workers are unorganized, undisciplined and underpaid than they are where a union exists. We feel convinced that in cases where both sides are responsible, no issue is so great that negotiation and arbitration cannot crack it.

The policy of Local 250, as stated to our employers repeatedly, is that we specifically renounce the strike weapon in return for a commitment to arbitrate any "insoluble" issues. The record speaks for itself. In the last fifteen years we have had two arbitrations, no strikes.

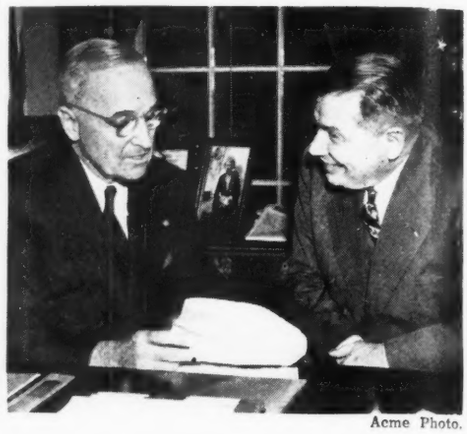
A new contract was recently negotiated with the San Francisco Hospital Conference. It took hard work around the conference table, with give and take by both sides. Our members received a wage increase. They enjoy a forty hour week, two weeks' vacation with pay each year, paid holidays, sick leave, union security. Neither the members nor the officers are wholly satisfied with our contract, but we think we have made progress.

We are proud of having contributed to stability in the industry, of having brought a better life to hospital workers, and of not having hurt anyone in the process.

# PEOPLE IN PICTURES

Acme Photo.

LEFT: Dr. Perrin H. Long, at right, presents the 1947 scientific award of the American Pharmaceutical Manufacturers' Association to Dr. Edward L. Bortz, president, American Medical Association, who accepted on behalf of the association. RIGHT: Carl R. Gray Jr., new Veterans Administration head, talks things over with President Truman at White House.



Acme Photo.

ABOVE, LEFT: Health insurance leaders discuss the problem, "Who Should Pay the Doctor?" at the monthly film forum of the Young Men's Hebrew Association. Left to right: Dr. Dean A. Clark, Michael M. Davis, Charles G. Spiegler, Dr. Harold Aaron, Dr. Samuel Z. Freedman and Louis H. Pink. RIGHT: Officers of the Greater New York Hospital Association and the United Hospital Fund commend Gov. Thomas Dewey for his support of the hospitals.

Lenna F. Cooper (right) receiving the honorary degree of doctor of science from Drexel Institute of Technology, Philadelphia. Ardenia Chapman, dean of Drexel's College of Home Economics, who wrote and delivered the citation, looks on while R. S. Hanson, professor of chemistry at the institute, places the doctor's hood on Miss Cooper. She is a co-founder and past president, American Dietetic Association.

# THE PHILADELPHIA STORY

## of Practical Nurse Training

**C. RUFUS ROREM**
Executive Secretary, Hospital Council of Philadelphia

INTEREST in the services and training of practical nurses found a new and special outlet in Philadelphia when the Board of Public Education established classes for training for the vocation of practical nursing.

The board has introduced a one year course composed of three months of classroom instruction in nursing technic and problems, to be followed by nine months of in-service training at affiliated hospitals in Philadelphia. During the entire course, the trainees will be students of the Philadelphia public schools. At the satisfactory completion of the course trainees will be given certificates in practical nursing.

Classes were opened October 15, with two groups of 25 students each in the Bok Vocational Technical School and the Mastbaum Vocational School. When the course was announced during the late summer of 1947, a total of 560 persons applied for training. Requirements for admission include one year of high school education or its equivalent, Philadelphia residence, age between 18 and 50 years, good health, good character references, a genuine liking for people, an interest in caring for the sick and American citizenship or the receipt of first papers. During the course of interviewing applicants, approximately 35 persons appeared eligible for, and were directed to, hospital schools for registered nurses.

### NEGRO APPLICANTS ACCEPTED

Several of the Negro applicants accepted for the practical nurse course were high school or college graduates who had been excluded from enrollment in schools for registered nurses. Among the white applicants the age concentration was between 30 and 40 years, with a substantial number of younger students who had insufficient funds or educational prerequisites for professional nurse education. Quite a few had already been caring for the sick as doctors' assistants or practical nurses. Some had previously studied in privately owned schools for practical nursing, of which there are at least eight in the Philadelphia area.

The development of the course in practical nursing was not a sudden decision by the board of education. Representatives of the school district of Philadelphia had held numerous conferences during the past several years with members of the nursing profession, particularly representatives of the Philadelphia district of the Pennsylvania State Nurses' Association. These conferences had arisen from the special problem of obtaining adequate enrollment in schools for registered nurses as well as the hospitals' problem of obtaining employes for certain tasks which had previously been performed by undergraduate nursing students. The Nursing Council of Metropolitan Philadelphia (successor to the War Nursing Council) had been studying national developments in the training of practical nurses.

Several years ago one of the leading hospitals in this area organized a school for practical nurses but discontinued the project because of legal complications of the Pennsylvania licensure act which appeared to restrict the administration of schools for practical nurses to institutions which did not maintain schools for registered nurses. The purpose of this regulation had been to avoid possible misrepresentation on the part of students graduated from separate schools administered by the same hospital.

When the board of education announced the present course for practical nurses, a number of hospitals inquired whether they would be legally permitted to affiliate with the program, inasmuch as they conducted schools of their own for the training of registered nurses. The matter was cleared with the State Board of Examiners for the Registration of Nurses, Department of Public Instruction, which made clear that the trainees would at all times be students of the Philadelphia public schools.

Their relationship to the hospitals would be merely that of apprentices receiving on-the-job training. The department of public instruction required that the duties in which the students were trained should be those properly assignable for practical nurses, and that the classroom instruction should be consistent with that recommended by the National League of Nursing Education for training of practical nurses.

Exactly one year ago the Graduate Hospital in Philadelphia inaugurated a one year course for practical nurses, enrolling a total of four students at two month intervals. These women are under the supervision of the director of nursing, and the first class of four trainees completed the course on January 1. The students live in the hospital and receive full maintenance during instruction. They pay $50 tuition and receive $20 cash monthly after the first three months.

### ELIGIBILITY NOT DETERMINED

The Pennsylvania law provides for voluntary registration of "licensed attendants" who comply with certain requirements. A proposal for compulsory registration was defeated in the 1947 legislature. Whether the holders of certificates awarded by the school district of Philadelphia will be eligible for registration or licensure has not been determined.

The program in its entirety has been approved by the Veterans Administration for G.I. benefits, and persons enrolling for the course as veterans are entitled to receive subsistence under the prevailing regulations covering education.

The three months of classroom instruction is held in the city school buildings. Classes are held five days a week from 8:30 a.m. to 3:15 p.m. Two days a week are devoted to the

study of elementary nursing technic, two days to food, nutrition and home management and the remaining day to such problems as ethics and working relationships of practical nurses, care of self and personal development, care of mother and baby, care of the normal child, care of chronic and convalescent patients, first aid and diversion therapy.

The course has as its objective the development of the ability to care for convalescent patients, chronic invalids, the aged, maternity patients and their babies in their homes, semi-acutely ill patients who do not need highly technical treatment.. The students will also be trained to serve as nursing assistants in hospitals and to perform housekeeping duties in the home.

When students have completed their three months' instruction, they will be assigned to affiliated hospitals which have agreed to comply with the requirements of the Philadelphia school district. Each student will bring to the hospital a chart listing the duties she is qualified to perform and for which the hospital agrees to provide practical experience. At the end of the period of in-service training, the hospital will give the public schools a report on the proficiency of each student.

The list of specific duties includes more than 60 items of which the following may be cited as illustrations: strip a bed, make an open bed, make a closed bed, fan bed clothing, move and turn patient, give morning care, give evening care, give a back rub, take temperature, pulse and respiration, prepare and give enemas, care of patient after death, care of instruments, feed baby, give oil bath to infant, apply abdominal binder, care of diapers, prepare food formulas.

The nine months' period (thirty-nine weeks) of training in hospitals will be divided as follows: seven months in a general hospital including two months in pediatric and maternity service and two months at the Philadelphia Home for Incurables. Within the general hospital the seven months (thirty-one weeks) will be divided as follows: four weeks each on the medical service for men and women; four weeks each on the surgical service for men and women; four weeks on the children's service; seven weeks' care of mother and newborn infant beginning five days after delivery; two weeks of night duty, and two weeks in the diet kitchen.

Hospitals that accept students will be expected to appoint a supervisor to direct their activities and to make regular reports to the supervisors from the public school system who will visit the hospitals from time to time. In addition to providing the experience in the various departments of the hospitals, the institutions will agree to pay the trainees $30 per month and to provide laundry service and one meal each day.

Following completion of the course, the Philadelphia public schools will test the proficiency of each trainee before granting a certificate. Every effort will be made to assist the certificate holders to obtain employment. The local official nurses' registry may consider inclusion of a program for placement of practical nurses. The hospital council is considering the problem of rates and reimbursements for practical nurses.

Invitations to hospitals for formal affiliation have been issued and more institutions have already expressed an interest than can be immediately accepted. After January 15, two more classes were enrolled.

The ultimate significance of a formal course of practical instruction for nurses cannot be overestimated. The experiment in Philadelphia has several characteristics which may make it important for the country as a whole. The cost of academic instruction is borne by the community through its public school system. The students must pay for and wear standard uniforms during the classroom period and their apprenticeship. The central instruction for students may establish a pattern which can be adopted by other public schools for the training not only of practical nurses but also of registered nurses. The procedure might even be applicable to municipal junior colleges or to universities.

#### PAY $30 PER MONTH

The provision of $30 a month payment removes a substantial burden from the students while in training. There is probably slight immediate economy for the participating hospitals, although the practical nurse students' services will be a substitute for the duties of students enrolled in professional nursing courses. Many tasks now performed by student nurses in training for their R.N. degree can properly be assigned to persons with less formal education and experience than are necessary for a professional nurse.

This introduction of a one year course suggests a contrast that may lead to sharp separation between "registered" and "practical" nurses. The first group may become supervisors after receipt of a college degree and adequate training to guide and teach people with less experience and understanding. The second group would be qualified to perform secondary duties in the hospital and to carry on housekeeping responsibilities and elementary services in the home.

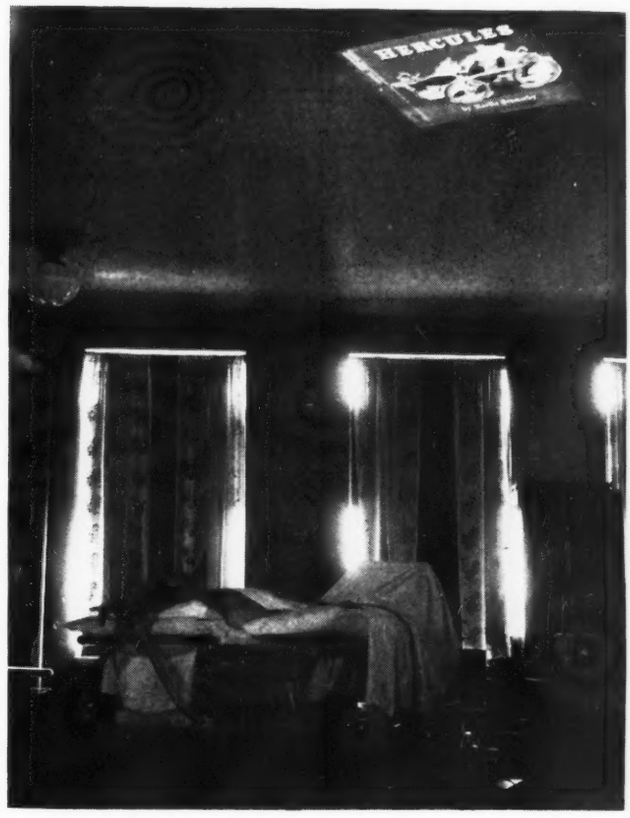
The policies and procedures of this program are not "frozen." They will be studied carefully with a view to improvement in subject matter and method.

The Philadelphia story is an interesting example of community-wide cooperation among the public schools, the hospitals, the nursing profession and the general public.

# The CEILING REFLECTS NEW HOPE FOR THE HANDICAPPED

**MARIAN HOLLWAY and REBECCA EILOLA**

Respectively, Teacher-Librarian, Social Service Library, and Elementary Teacher, Hospital School
University Hospital, Ann Arbor, Mich.




**Patients find it pleasant and easy to read this way.**

THE social service library at the University Hospital, Ann Arbor, Mich., was established to make available to patients reading materials for information, leisure and vocational selection. The library plays an intrinsic part in the life of the patient who may go to the library and make his own selection or be served from the new library cart by the librarian on her regular schedule to the wards. Functioning as a teacher-librarian on an adult education level, she supplies the latest in news in a variety of languages and publications, fiction, mystery, drama, hobbies and other subjects, with books, magazines, newspapers and bulletins.

Her service is supplemented by many types of audio-visual equipment, including radio, lantern slides and ceiling projects for those unable to turn pages or hold books. While patients are improving their reading level, they increase their knowledge and take great pleasure in both recreational and informative reading. Books, magazines, newspapers, the book cart and all visual aids are the gifts of many individuals.

Among these gifts are the ceiling projectors which were placed in our library in July 1946 by the Projected Books, Inc., Ann Arbor, for the purpose of experimenting with them and discovering their uses and difficulties, if any. Because our program is never static and we are always trying out new and different methods, technics and equipment to meet the wide variety of physical, mental and emotional problems presented by patients, it was only natural that such equipment would be welcomed for trial.

Many patients, because of their inability to hold or turn reading material in the ordinary way, are restricted in following their normal reading interests. With the advent of the ceiling projector, they are able to enjoy a reading program comparable to that available to others not handicapped by traction, casts and other treatment devices.

The ceiling projector is a light, compact, portable electric machine, housed in a convenient carrying case, and has a small readily movable table on which it can be placed near the patient's bed. It operates with three buttons on a plastic strip that can be held by the patient, pinned to the bed or placed in any spot convenient for the patient. Its simple push button control projects the microfilmed pages on the ceiling in a satisfactory reading location. With a simple finger movement on the button, he may turn or reverse the pages as desired.

Patients of all ages now find this a pleasant and effortless way of reading. The time spent in reading is certain to furnish a welcome relief from emotional strain and tension and helps the patient make a more satisfactory adjustment to his period of hospital care.

The librarian must have a friendly and serene approach to the patient, an objective attitude, and must demonstrate a genuine interest in him. She must be aware that each patient is an individual, having his own interests and abilities, and that no illness affects two persons in the same manner. The medical diagnosis must be considered. The librarian is trained to take cognizance of diagnoses, physical handicaps and individual differences of patients. She confers regularly with the medical case worker as to the physical condition and recreational needs of each patient. Then she explores his reading interest with him by discussing previous reading interests, his home, his hobbies and familiar topics which will provide clues to the types of books he will enjoy most in his first experience with the ceiling projector.

The projector, which provides a novel easy way to read, intrigues the

imagination of individuals and almost without exception they are eager to try it. Nevertheless, danger signals must be detected in that someone might feel that such a manner of reading would emphasize his handicap and thus create a mental hazard for him. Sharing the projector with other patients and the interest of onlookers in the machine help alleviate this hazard. Inasmuch as it is just one of the numerous recreational facilities which the social service department makes available to patients, there is no feeling created that it is provided exclusively for his particular handicap.

Cartoons, light fiction and mystery stories are the film books most frequently read first. Because reading is an almost unrestricted activity for patients here, the librarian would rarely, if ever, have to wait for a special request from the doctor before making the ceiling projector available. The medical staffs, however, frequently introduce the idea of the projector to patients and refer the suggestion to the librarian, as in the case of Tony, who had transverse myelitis, was on a frame, and was markedly limited as to motion. Added to all of this was his mental attitude of hopelessness toward recovery and toward his ability to do anything.

Pressing the button of the projector was the simplest constructive activity that could be suggested. To Tony who had considered himself totally helpless this was a major accomplishment. It brought him reading materials of concern to him in a position which he could see in spite of his frame. From this simple movement of the machine, he was motivated to other tasks within his physical limitations.

One of our most successful contacts in establishing a reading program with the ceiling projector was with Ned, who had spondylitis rhizomelica, could view his surroundings by mirror only, and spent all of his time feeling sorry for himself and thinking of his distressing condition. For years he had not read a book and even one of very light weight was more than he could manage. His doctor suggested the ceiling projector to him and although he knew why the suggestion was made he questioned how useful it would be to him.

As soon as it was set up, however, he became intensely interested, beginning with detective stories, then extending his reading to travel, biography and historical novels, reading every book thoroughly and averaging two or more a week. Many discussions pertaining to the books ensued. This opened up a new world to him. As a result of his reading and recognition of his ability to give something to others, he shared his experiences with others in the ward and laughed and had fun with them.

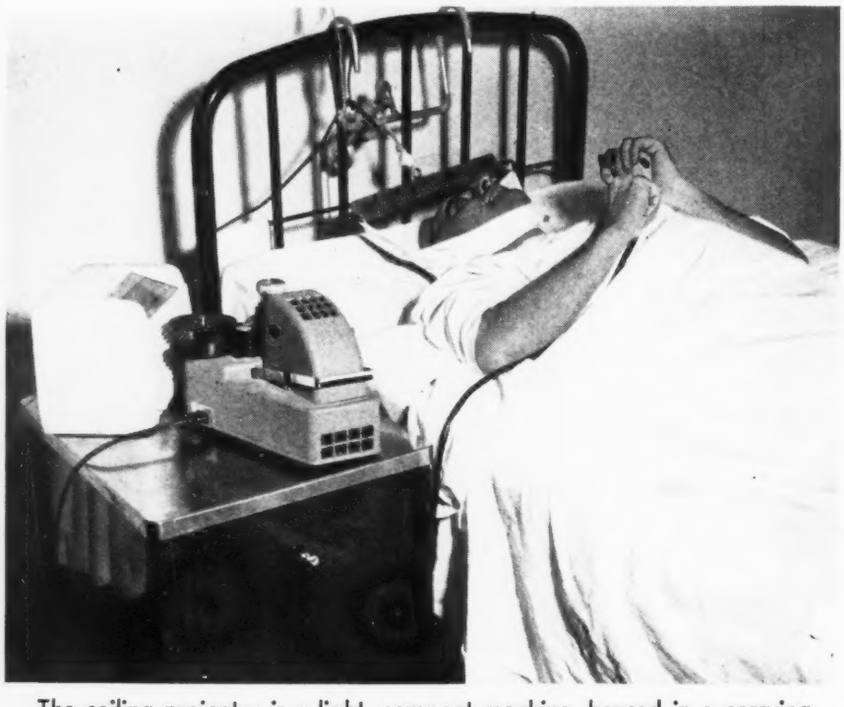
Children and teen agers find that a period of illness imposes upon their free spirit of play and activity. It is often difficult for them to adhere to bed rest and the multiplicity of restrictions. Days of loneliness and emptiness follow. Such was the case of three little boys aged 5, 6 and 7 who were being treated for poliomyelitis. Interesting, constructive and simple play activities were needed for these three boys, especially activities that would draw their attention away from themselves and develop social mindedness.

When the projector was taken to the boys, their interest was aroused instantaneously. Projected Books, Inc. has numerous good films on the beginning reading level which were just right for these boys. They needed little instruction on the use of the machine and could read the films together because their beds were placed adjacently. Many hours were occupied in reading films together, in looking at illustrations and discussing the stories. One boy changed from a fearful shy individual to a happy social boy.

The projector has been used in various situations for numerous purposes, as in the case of Jimmy, a 13 year old boy, who cried and screamed when he awoke from the anesthesia and learned that he was in a body cast with only one free arm. The projector, in addition to being an interesting diversion for this boy, proved to be a valuable means for developing an insight and understanding with his teacher who took the machine to him.

Jimmy had many fears of hospitalization and surgery. His mental attitude toward the hospital regime was poor and he was quite negatory toward his medical care, wholesome play activities and his school instruction. He was retarded in his school work. Although the teacher had seen him when he had been in the hospital on previous visits, he did not give any indication of wanting or being able to read until he used the projector.

Through the reading of the book films, the teacher was able to institute a play and school program which later, when the cast was removed, developed into a daily activity that filled much of his leisure time. As a result of this program there was a decided personality change in the boy. He dropped his bad habits of crying and whining and became courteous. When he discovered that he could read well, he overcame the feeling of inferiority



**The ceiling projector is a light, compact machine, housed in a carrying case and has a small table on which it can be placed near the bed.**

about his school work and was willing to work at the level of his ability.

The ceiling projector has been adapted to use by all types of patients, including professional persons, among others. A graduate nurse who had osteomyelitis of the spine filled her leisure time with a light type of fiction which was a change from her more serious reading. Reading book films was one of her few activities.

Not infrequently the mere mechanics of operating the projector appeals to some. Bob who had tuberculosis was an automobile mechanic prior to his illness; consequently, the mechanical manipulation intrigued him. He studied the manual which accompanied the machine and explained in detail the mechanics and operation of the machine to the librarian and others. As his enthusiasm for the machine extended, he read more and more films in spite of the other reading materials that were accessible to him.

The ceiling projector has had multiple uses with all ages and many diagnostic groups and has been found to have numerous possibilities for adaptation. Obviously it must be set up and adjusted to meet the individual needs of the patient and must be properly serviced.

# VOLUNTEERS TAKE UP RECRUITMENT

**MRS. PHILIP CONNER**
Member, Women in Yellow
Jefferson Davis Hospital
Houston, Tex.

JEFFERSON DAVIS HOSPITAL School of Nursing, Houston, Tex., has joined the nationwide campaign to enroll high school graduates in the classes for the coming terms. With the acute shortage of graduate nurses all over the country, it has become imperative to interest prospective nurses in this profession that has so much to offer. A diploma means security for life.

With A. S. Reaves, superintendent of the hospital, acting as honorary chairman on each committee of this campaign, and Mrs. Elizabeth Nichols, director of the school of nursing, as co-chairman, a program to bring this opportunity for a worthwhile career before girls and young women between the ages of 16 and 30 is well under way.

Personal letters and information bulletins, posters and pictures have been sent to key persons and organizations in the area adjacent to Houston. Publicity letters and articles covering the subject have been sent to many newspapers in Texas and other publications and periodicals. A 16 mm. technicolor film has been made showing student nurses in this hospital going about the routine of their daily lives, stressing the splendid experience they derive from its clinical advantages. These pictures are being booked for showings before the student bodies of high schools in Houston and many of the smaller towns in the surrounding territory.

The contact committee is composed of doctors and nurses who make appointments to give personal talks before groups of prospective student nurses. Appeals have been made to presidents of women's clubs, parent-teacher organizations, county Red Cross chairmen, county home demonstration agents, secretaries of Rotary clubs, Chamber of Commerce, Lions' clubs, Kiwanis clubs, Optimists' clubs and Y.W.C.A. branches, all of whom are happy to lend their cooperation.

Feature stories have been written in Houston newspapers. Announcements are being made over the various radio stations. Ministers of the different churches are giving their assistance by telling their congregations of the need for nurses. Heads of all the various departments in Jefferson Davis Hospital have written interesting and informative articles of what they accomplish in the hospital. Emphasis is placed on the pleasantest features of the lives of nurses, as well as on the good they do in the community in which they reside.

The school of nursing is approved by the Texas Board of Nurse Examiners and is affiliated with the University of Houston. A graduate has 60 semester hours of college work to her credit when she completes the course.

The Women in Yellow, Jefferson Davis Hospital's auxiliary of volunteer workers, does a great deal to help carry on the work of assisting nurses. This group is affiliated with the American Hospital Association. Each member who gives one hundred or more hours of work in the hospital in a year's time is awarded the A.H.A. pin at the annual meeting. Not only do these women lend a helping hand, doing all they can for the comfort and cheer of the patients, but they have a committee to provide and supervise wholesome entertainment and amusement for the student nurses when off duty.

**Pictures like this one showing student nurses at their studies help in the recruiting program that was initiated by the "Women in Yellow," Jefferson Davis Hospital's enterprising women's auxiliary.**

# SMALL HOSPITAL FORUM

## RATES AND OCCUPANCY

THE bed shortage has eased somewhat in the last year, a survey of 27 hospitals in various sections of the country would indicate. In a few cases, relief from the pressure for hospital space has come through construction of additional facilities. For the most part, however, demand has slackened —possibly owing to continued increases in the cost of hospital care, in the opinion of some observers.

Seven of the hospitals surveyed are in the Middle West, five are in New England, four in other eastern states, four in the South, three in Canada, two in the Far West, and two in the Southwest.

Sixteen hospitals in the group report the existence of a bed shortage in their communities; the remaining 11 say no shortage exists. Only two hospitals report that the shortage is more severe now than it was a year ago, whereas eight institutions say the demand for beds has noticeably eased up. Fifteen administrators say the situation seems about the same in their hospitals.

Specifically, these hospitals report an average occupancy today of 76 per cent of bed capacity, compared to 78 per cent for the same hospitals a year ago. In a few individual cases, the situation has changed drastically. One hospital, for example, has dropped from 80 to 50 per cent occupancy in the last year; another, from 100 to 80 per cent, and another, from 95 to 85 per cent. Five of the hospitals, on the other hand, show slight increases in occupancy, and 15 report the same occupancy for today that prevailed a year ago.

Significantly, only four of the eight hospitals which have lower occupancy today than they had last year can attribute the change to construction of additional hospital facilities in the area during the year. In the other cases, the demand for beds has apparently diminished. In the four cases where relief came through new construction, a hospital of 100 beds completed an addition of 47 beds; another of 150 beds added 50; a 60 bed institution expanded to 85 beds, and a 75 bed hospital added 10. In all these cases, the additional facilities were reflected in the reported occupancy figures.

A few administrators offered comments in connection with their reports on demand. One who reports about the same pressure for beds that existed a year ago added this observation: "However, because rates are higher, many patients leave just a little quick-

### THANKS TO THESE CORRESPONDENTS

| HOSPITAL | RESPONDENT | BEDS |
|---|---|---|
| Northwood Deaconess Hospital, Northwood, N. D. | Albert Hagen | 25 |
| Garnier Clinic, Bastrop, La. | Mrs. Lois Sisson, R.N. | 30 |
| Nasau County Hospital, Fernandina, Fla. | Mrs. P. Egan | 30 |
| Cimarron Valley Osteopathic Hospital, Yale, Okla. | Margaret Hiner | 30 |
| Medina Memorial Hospital, Medina, N. Y. | Estella Douglas, R.N. | 36 |
| Plymouth Hospital, Plymouth, Wis. | Mrs. Marthe Downing, R.N. | 42 |
| Cache Valley General Hospital, Logan, Utah | Elva M. Struckus, R.N. | 43 |
| Prescott Community Hospital, Prescott, Ariz. | E. E. Johnson | 44 |
| Peabody Memorial Hospital, Webster, S. D. | Thomas E. Hagen | 45 |
| Springfield Hospital, Springfield, Vt. | N. Gertrude Sharpe | 47 |
| Charles Choate Memorial Hospital, Woburn, Mass. | Wilford A. Walker | 52 |
| Walla Walla General Hospital, Walla Walla, Wash. | W. E. Guthrie | 53 |
| Findlay Hospital Association, Findlay, Ohio | M. J. Thompson | 76 |
| Day Kimball Hospital, Putnam, Conn. | W. N. King | 80 |
| Peoples Hospital, Jasper, Ala. | David C. Akins | 85 |
| Pulaski Hospital, Pulaski, Va. | V. A. Hylton | 85 |
| Bridgeton Hospital, Bridgeton, N. J. | Ida D. Squarewood, R.N. | 94 |
| Christ's Hospital, Topeka, Kan. | Lilyan Zindell | 100 |
| Milford Memorial Hospital, Milford, Del. | Charles E. Varney | 100 |
| Osteopathic Hospital, Kansas City, Mo. | | 100 |
| Trail-Tadanac Hospital, Trail, Can. | Vera B. Eidt | 120 |
| Monongalia General Hospital, Morgantown, W. Va. | P. J. Mehlinger | 125 |
| Brockville General Hospital, Brockville, Can. | W. E. Cooke | 126 |
| Lutheran Hospital, Omaha, Neb. | L. Angwert | 130 |
| Elliot Community Hospital, Keene, N. H. | Dorothea W. Rice | 150 |
| Woonsocket Hospital, Woonsocket, R. I. | Leroy P. Cox | 167 |
| P. E. I. Hospital, Charlottetown, P. E. I. | Anna Mair | 200 |

er, and this relieves the strain somewhat."

"Sometimes prospective patients have to wait if they specify certain accommodations," another administrator says, explaining the extent of the pressure in his community, "but we have always been able to take care of our patients if they are willing to take the beds that are available. At times we place extra beds in sunrooms, but that is only temporary."

Several others also explain that shortages apply only for beds in certain types of accommodation at certain times—in contrast to the situation a year ago, when all types were pretty well filled.

### PLAN TO BUILD

Twelve of the 27 hospitals reporting here indicate that specific plans have been made for the construction of additional facilities at some future date. In eight cases, a time limit within which the contemplated construction is expected to take place is named; for the most part, one to two years is the period stipulated. In two cases, no time is specified, and in the remaining two it is indicated that the project will be carried forward "as soon as building costs go down."

The future construction plans in every instance are for fairly substantial additions to existing plants. In one case, for example, a 75 bed addition is planned for a 75 bed hospital; others call for 40 beds to be added to 50, 50 to 100, 30 to 80, 20 to 45, 25 to 25, and so on. Fifteen hospitals in the group are not planning any expansion of existing plants.

Twenty-three of the 27 hospitals have increased the rates charged to the public for rooms or services at least once during the last year, the reports indicate. Three of these hospitals do not state the amounts by which rates were raised. In two other cases, the increase was a straight $1 a day for all room or bed charges. Percentage increases reported by the other hospitals range from 9 to 35 and average 17. Two hospitals raised rates 35 per cent, one added 25 per cent, four upped the charge 20 per cent, and many entered comparatively modest increases of 15, 12.5 and 10 per cent.

In 19 of the 27 reporting hospitals, there is no evidence that the public thinks rates are too high, and there was no objection to the increase when it was announced. "Very few comments," one administrator observes. "No letters, perhaps an exclamation or two, but generally I believe there have been fewer expressions lately than during the war period."

"Have heard only two adverse comments from patients or relatives," another administrator writes, "Most of them realize the necessity for increases. However, doctors report adverse criticism, which I think is exaggerated."

The remaining eight hospitals report some resistance to the existing rate structure or some criticism of the increases. "Some of the doctors think our rates should not have been raised," one of these administrators says. "We have some complaints about high rates," another states, "but most people are considerate and realize that the increased rates were necessary because of higher prices for foods and other supplies." Others report scattered complaints but add that these were verbal and not serious.

Only four of these hospitals definitely contemplate a further increase in charges during 1948, but 12 others indicate that such an increase may be necessary if their costs continue to rise as they have been doing in recent months. Eleven hospitals believe that they will finish the year at today's rates regardless of the general price trend.

Seven of the hospitals have taken specific steps to acquaint the public with hospital problems, and particularly with the cost facts that have made high rates, and rate increases, necessary. Mostly, this effort has taken the form of newspaper stories and bulletins issued by the hospitals. In other cases, the administrator has made talks at chamber of commerce and Rotary club meetings and other public gatherings.

For the most part, it is indicated, such activity makes it easier for the hospital to raise rates as circumstances require without meeting too much objection. One administrator, however, reports that the newspaper publicity placed by the hospital faces an impossible task. "The public thinks the hospital is making a tremendous profit," he states.

At least one other administrator thinks that attempts to gain public understanding are vain, not because they aren't needed but because they don't accomplish anything. "Those who believe our rates are too high simply cannot be convinced of their necessity, in my opinion," he asserts. "The doctors have asked us to cut down on our office force and maintenance of grounds, for example, in order to save money and make a further rate increase unnecessary. Actually, this would save a maximum of 20 cents a day and make this hospital a poorly administered business and a poor looking place to come to."

# VOLUNTEER ACTIVITIES

### Project After Project

Ten Kansas City women founded the Brace Club 10 years ago. Its purpose was to provide braces, corrective shoes and treatment for dispensary patients of Menorah Hospital in Kansas City, Mo.

Now known as the Marcella Rodin Club, this little band has taken on project after project, its latest being the purchase of a wading tank for the after treatment of poliomyelitis patients and those with other orthopedic conditions.

In an intensive campaign the women raised the necessary $5000 for the pool. The fact that the hospital had just treated 102 polio patients in a three months' period made the task lighter.

The chief source of revenue was a souvenir booklet for a dinner dance held at a local hotel. The women solicited advertising for the booklet, being assisted by the junior auxiliary.

The pool will be placed in an addition to the hospital. This addition also will house a department of physical medicine and the Marcella Rodin Club is to supply funds to help equip this department. Mrs. Harry Sircus is president of the club.

### Dads v. Juniors

Davis Hospital, Pine Bluff, Ark., has an interesting auxiliary known as the War Dads. This group recently contributed $330 for the purchase of an electrically heated tray conveyor. The Junior Auxiliary outdid the Dads by raising $825 to redecorate and equip the pediatric ward.

# ABOUT PEOPLE

## Administrators

**John F. McCormack,** former superintendent of Presbyterian Hospital, New York City, has been appointed executive vice president of United Medical Service to facilitate joint activities of the organization and its affiliate, Associated Hospital Service. Mr. McCormack is a former delegate to the American Hospital Association, a past president of the New York State Hospital Association, the Greater New York Hospital Association and the Hospital Bureau of Standards and Supplies.

**John F. Barker** has accepted an appointment at Wesley Memorial Hospital, Chicago, as administrative assistant, with supervision of the admitting, cashiers', information, pages, elevator, and telephone and communications services and the outpatient department.

**Stanley R. Schulman** has resigned as superintendent of the Union Health Center in New York City to accept the position of director of the Home for the Aged, Trenton, N. J.

**Clarence M. Taylor** is the new administrator of Cleveland Clinic Hospital, Cleveland. He was formerly with the Lincoln Electric Company of Cleveland and held the post of executive vice president at the time of his resignation from that organization.

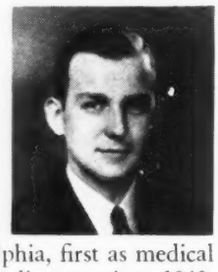
**Sister Mary Raymond** has been appointed administrator of the Queen of Angels Hospital, Los Angeles, succeeding **Sister Mary Frebonia** who will become administrator of St. Joseph's Hospital, San Francisco. Both hospitals are operated by the Franciscan Sisters of the Sacred Heart. Sister Mary Raymond came to Los Angeles from the Sisters' headquarters at Joliet, Ill. The Order has also announced the appointment of **Sister M. Urbana** as head of St. Francis Hospital at Santa Barbara, Calif.

**Louis B. Blair,** administrator of the Starling-Loving University Hospital, Columbus, Ohio, has been named to succeed **Rev. E. T. Gough** as head of St. Luke's Methodist Hospital, Cedar Rapids, Iowa.

**Leonard W. Hamblin** has accepted the position of administrator of Deaconess Hospital, Freeport, Ill., succeeding **Harry D. Keller.** He took over his new post on January 2. Previously, Mr. Hamblin had been assistant administrator of Jewish Hospital, Cincinnati.

**Stuart W. Knox,** recently superintendent of Pekin Public Hospital, Pekin, Ill., has taken the position of superintendent of Lawrence General Hospital, Lawrence, Mass. He succeeds **Beatrice K. Barnes,** who resigned on November 15. Mr. Knox is a member of the American Hospital Association, the Illinois Hospital Association and the Massachusetts Hospital Association.

**John T. Kolody** has been appointed assistant superintendent of St. Barnabas Hospital for Chronic Diseases, New York City. Mr. Kolody received his master of science degree in hospital administration from the school of public health of Columbia University last October. Prior to that time he served a year's residency in hospital administration under **Dr. A. P. Merrill,** administrator of St. Barnabas.



**Dr. Philip D. Bonnet** has been appointed superintendent of Massachusetts Memorial Hospitals, Boston. Dr. Bonnet has been associated with Lankenau Hospital in Philadelphia, first as medical director and then as director, since 1940. He succeeds **Dr. Leverett S. Woodworth** who recently resigned to accept a position with the Veterans Administration. Dr. Bonnet will assume his new duties March 1.

**Kenneth E. Brooks** was appointed assistant administrator of Westlake Hospital, Melrose Park, Ill., on January 1. Prior to this appointment Mr. Brooks was administrative intern in the hospital. He is receiving his bachelor's degree in hospital administration at Northwestern University this month.

**Rev. Irwin E. Heckman** of Fremont, Neb., has been named district superintendent of the Lutheran Hospitals and Homes Society of Fargo, N. D. He will supervise work in institutions conducted by the Order in Nebraska, including Lutheran Hospital, Columbus; Lutheran Hospital, Grand Island, and Memorial Hospital, North Platte.

**E. Vernon Rich,** superintendent of Laconia Hospital, Laconia, N. H., has resigned to accept a position as superintendent of Symmes Arlington Hospital at Arlington, Mass. Mr. Rich was appointed head of the Laconia Hospital June 1, 1946.

**Ray E. Brown,** superintendent of the University of Chicago Clinics, has been appointed associate professor of hospital administration and also as associate director of the course for hospital administrators, university officials announced recently.

**Daniel M. Brown** has left his position as administrative assistant at Permanente Foundation Hospital, Oakland, Calif., to assume the duties of administrator-consultant of the new Lodi Memorial Hospital, Lodi, Calif., which is to be built this year. This is a voluntary, nonprofit hospital for which funds have been and are being raised by popular subscription. The institution will eventually have a capacity of 150 beds.

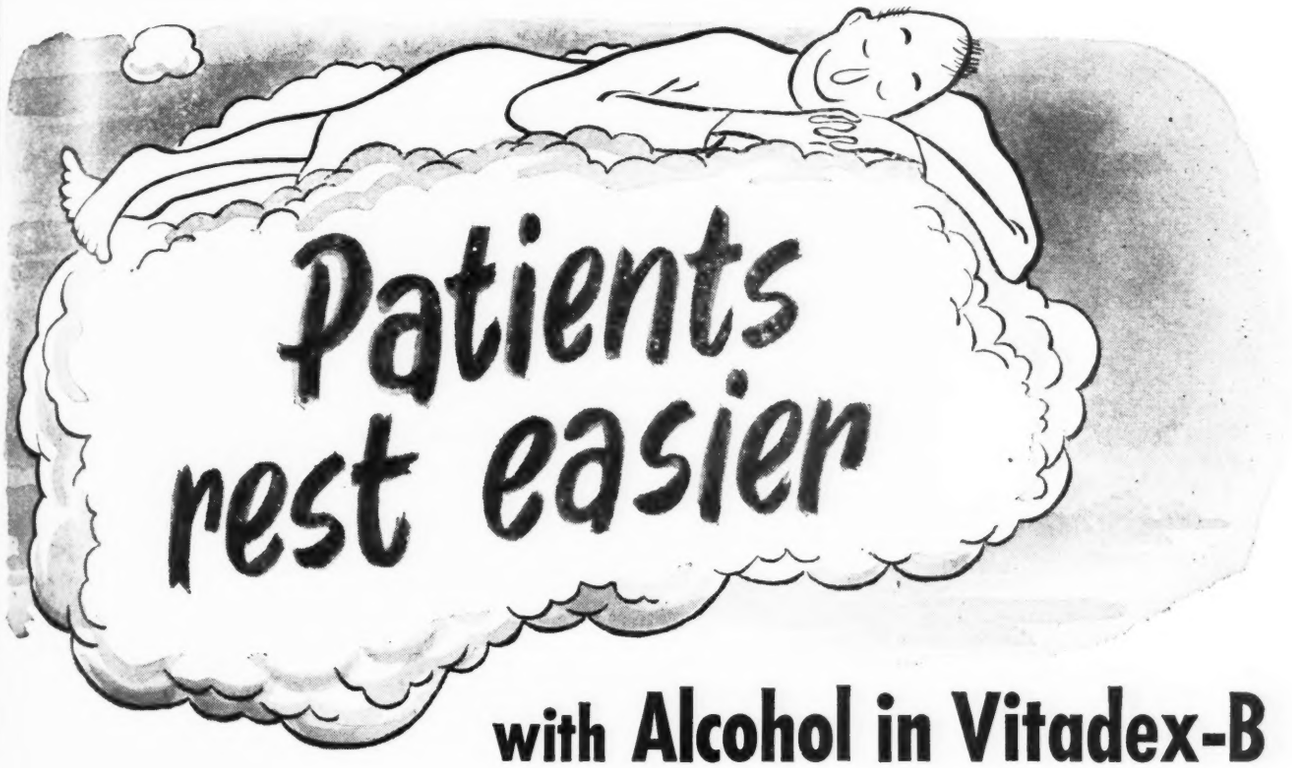
**Hans S. Hansen** has been appointed administrator of Grant Hospital, Chicago, succeeding **Robert Graves.** Mr. Hansen has been chief pharmacist of the hospital.

**Frederick G. Whelply** has been named to succeed **A. James Behrendt** as assistant director of Evanston Hospital, Evanston, Ill. Prior to this appointment Mr. Whelply served an administrative internship at Evanston.

**Vernon T. Root,** former Indiana hospital administrator and more recently associated with the Indiana Blue Cross plan, has taken over the position of administrator of Community Hospital, Battle Creek, Mich.

**Richard Hocking** has been appointed administrator of Memorial Hospital, South Bend, Ind., succeeding **Ella Mae Doty,** who has been acting director. Miss Doty recently married **R. T. Dunlap** and is retiring from hospital work.

(*Continued on Page* 184)

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Patients experience a sense of confidence and well-being — are calm and relaxed — with Alcohol in Vitadex-B. Clinicians report* such satisfactory sedation post-operatively that, in most instances, opiates and other sedatives may be eliminated entirely. Patients are pleased. So are you.

*Behan, R. J., *Am. Jour. Surg.*, 69:227-229, Aug., 1945
Moore, D. C. and Karp, M., *Surg. Gyn. Obst.*, 80:523-525, May, 1945
Craddock, F. H., Jr., Craddock, F. H., Sr., *Mr. of Med. Assoc. of Alabama*, Nov., 1942

### Advantages over morphine

- More prolonged action
- Stimulates respiration
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Besides the analgesic and caloric advantages of alcohol, this solution supplies the nutritive value of dextrose — plus generous amounts of the B vitamins necessary for alcohol and dextrose metabolism.

SUPPLIED IN CUTTER SAFTIFLASKS
This conveniently combined solution, ready for immediate intravenous administration, comes in 1000 cc. Saftiflasks.

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| Dextrose 5% | 50 grams |

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Alcohol 5% in Normal Saline
Alcohol 10% in Normal Saline
Alcohol 5% in Distilled Water
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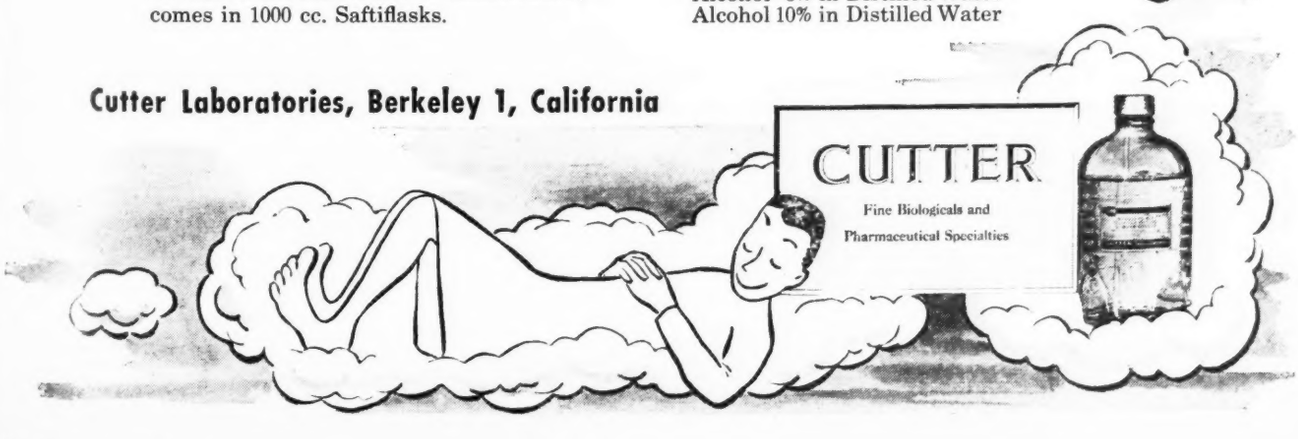

# TRUSTEE FORUM

CONDUCTED BY RAYOND P. SLOAN

W. FREELAND KENDRICK

## WHO ARE OUR HOSPITAL LEADERS?

**RAYMOND P. SLOAN**

THE "world's greatest philanthropy" it has been called, to which appellation no one who has followed closely its progress during the last twenty-five years is likely to take exception. It constitutes hospital service to indigent crippled children rendered by the Shriners of North America in twelve institutions in the United States, two in Canada and one in Hawaii. It represents a total investment of some $10,000,000, costs $1,000,000 annually to operate and has behind it a permanent endowment fund of $25,000,000 given in bequests and legacies by those who love children. Heading the organization is the man who first united the Shrine in this great humanitarian movement, W. Freeland Kendrick, onetime mayor of Philadelphia.

### CHILDREN BY ADOPTION

As he sits in his office in the Quaker City, slim, dapper, keen despite his three-score years and ten or more, Mr. Kendrick talks of the Shriners' Hospitals as he might of his children. Their patients are his children by adoption, for it is because Mrs. Kendrick and he had no children of their own that they first became interested in the children of others, particularly those who some sad fate had relegated to lives of invalidism.

No child in the wards of a Shriners' Hospital was ever more enthusiastic at being able to walk again than is Mr. Kendrick over the accomplishments in transforming what once were "Homes for Incurables" into "Temples of Smiles." His voice rings with enthusiasm as he tells of the million dollar expansion program now under way, which will include research into the causes and treatment of crippling diseases. Soon, or when building costs fall within reason, there will be new Shriners' Hospitals in Los Angeles and Salt Lake City. These should help to reduce the waiting list of thousands of young patients who seek treatment.

Mr. Kendrick doesn't like to think of these cases. The present total capacity of Shriners' Hospitals seems so inadequate. Yet there is always the satisfaction of knowing how many have been restored to lives of partial or complete usefulness in such communities as Shreveport, La.; Minneapolis and St. Paul; San Francisco; Portland, Ore.; St. Louis; Springfield, Mass.; Chicago; Philadelphia; Greenville, S.C.; Spokane, Wash.; Salt Lake City, Utah; Lexington, Ky.; Honolulu, T.H., and Montreal and Winnipeg, Can. For the entire plan of hospitalization is based on the policy of carrying the hospital to the children through establishing institutions in strategic geographical areas rather than carrying the children to the hospital.

The idea for providing medical care and treatment for indigent crippled children, without regard to their race, color or religion, was conceived many years ago when Mr. Kendrick was taken by a friend to visit the Children's House at the Home for Incurables in Philadelphia. Not only did his trip through the building make a great impression upon him but his conversation with the three or four young patients whom he later took for a ride in his automobile became indelibly imprinted on his memory.

"After that," as he tells the story, "I visited the institution more frequently and became more and more interested in those unfortunate and almost friendless broken bits of humanity.

"Why not initiate a movement among the Shrines of North America to rehabilitate destitute crippled children?" he began asking himself and others. The answer was found in the form of a Crippled Children's Club which he organized among his friends at the local Temple. Entertainments and parties were planned for the children and they were taken on automobile rides. This work continued over a period of years during which time Mr. Kendrick and his brothers of the order became better informed and more cognizant of the great need of meeting the problem of the indigent crippled child.

### RECOMMENDS BUILDING OF HOMES

This was prior to 1919. In June of that year having been elected to the office of Imperial Potentate of the Nobles of the Mystic Shrine of North America, Mr. Kendrick recommended plans for building homes and hospitals for orphaned, friendless and crippled children.

The idea was favorably received but it was decided to withhold definite action for another year. Not content to let the matter rest with the possibility of being tabled, its sponsor started to campaign in its behalf.

"During that year," he says, smiling reminiscently, "in company with Mrs. Kendrick I traveled more than 100,000 miles visiting the Shrine Temples of North America. At every opportunity and in every address I delivered, I preached the gospel of the destitute crippled child and everywhere we met the same generous response and the same sympathy for these unfortunate ones that we had experienced at home in Philadelphia.

# *The New Oral Method*

## of Penicillin Administration to Infants and Children

Soluble Tablets Crystalline Penicillin provide a new and convenient means of instituting penicillin therapy in infants and young children. These small tablets of crystalline penicillin G potassium are composed entirely of penicillin, and contain neither binder nor excipient. Readily soluble, they may be administered with the milk formula to infants, or dissolved in milk or water before being given to young children. Thus the need for hypodermic injection is obviated in the treatment of many penicillin-responsive infections and administration can be made by the mother. Their presence in solution produces no discernible alteration in taste. Dosage, 100,000 units or more every 3 to 4 hours.

Each Soluble Tablet Crystalline Penicillin contains 50,000 units and is individually sealed in aluminum foil.

Supplied in boxes of 24 tablets and available at all pharmacies.

*C.S.C. Pharmaceuticals*

**A DIVISION OF COMMERCIAL SOLVENTS CORPORATION**
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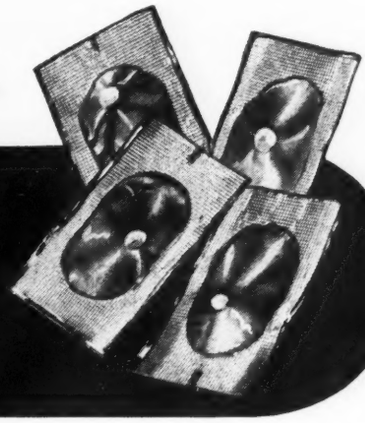

**Soluble Tablets**

*Crystalline Penicillin*

"You can well imagine how grateful I was when on June 24, 1920, my recommendations were adopted and a resolution was passed committing the order to this great philanthropic movement. At last the order had united in selecting a living monument as evidence of the worthwhile existence of the Shrine."

And so it happened that a committee of seven was appointed and plans for the future were discussed. Later, a board of trustees was named and in the latter part of 1922 the first Shriners' Hospital for Crippled Children, a 50-bed unit in Shreveport, was opened. Once its need was demonstrated, plans were developed for hospitals in other points.

The Shriners' Hospitals are operated by a board of twelve trustees scattered all over the country. Regularly they meet to review and discuss the administrative and financial problems of the different units. In addition, there are local boards of governors, nobles of the order, who are responsible to the trustees for the affairs of their individual hospitals.

Overall administrative policies and supervision are centered in the superintendent of the San Francisco unit who not only recommends to the board of trustees the superintendents of the other hospitals but makes annual inspections of each hospital and files a complete report with the board.

Chief surgeons of the various units, who receive compensation for their services, are selected by the advisory board of orthopedic surgeons.

#### OWNED BY IMPERIAL OFFICES

The hospitals are owned by the Imperial Offices of the Shrine, each institution receiving a yearly budget which is met through the national fund. Operating costs are covered by annual hospital dues for which each noble is assessed. Permanent contributing memberships are provided for those who would do even more. While the major financial support comes from within the order, there are others who, impressed by the value of the work, contribute to its continuation and expansion.

The centralization of hospital administration has contributed considerably to the economy and efficiency with which the individual units are operated. An example of this is revealed in the central brace factory, operated by the board of trustees in Atlanta, Ga. Here, parts for braces are manufactured and shipped to the various hospital units as ordered. Experienced brace makers in each hospital make repairs, enlarge or adjust braces and orthopedic equipment under the direction of the chief surgeon in charge of the unit. The Atlanta factory has not only effected savings but has increased the turnover in the hospitals by avoiding delay in the manufacture of braces and equipment for children otherwise ready to return to their homes.

There is no restriction of territory from which the Shriners' Hospitals receive their patients. Panama, Manila, Puerto Rico, all were represented in the records of one of these hospital units not so long ago. A youngster with the sponsorship of a Shriner may be of any race, color or religion so long as he or she is under 14 years of age, but without parents or guardians financially able to pay for surgical treatment. Also there must be reasonable hope that orthopedic surgery will rehabilitate these children to the point that they will become useful citizens and not charges upon the community in which they reside. Thus, congenital types of club feet, old fractures, scars caused by old burns, among other types of orthopedic work, are treated, many being discharged as completely cured or materially improved. Acute cases of infantile paralysis are not accepted.

In addition to the hospitalization of these crippled children, the various units have ever growing outpatient departments. According to Mr. Kendrick, in some instances the number of children treated in the hospital clinics is several times the maximum bed accommodations of the hospital. He tells, too, of clinics that are held at other points once each year, Utica, N.Y., for example, and also Powellton, W.Va.

With the Shrine sponsor serving as follow-up man, children are assembled in sufficient numbers to warrant sending the hospital superintendent and a doctor with a stenographer to take records and make notes. They make corrections on the shoes or braces of children who have been patients of the hospital or are on the waiting list.

Everything possible is done to minimize the hospital atmosphere in what the Shriners affectionately call the "Temples of Smiles" or "Mercy Houses." Bright colors are introduced in the furnishings, and games are provided, including stamp collections for the boys. In one institution visited recently, music instruction on the harmonica and string instruments was provided. In this hospital, too, every patient was dressed, whether or not he was off the bed, just to maintain his interest in clothes. Thanks to the cooperation of the women's groups, screen covers were embroidered in amusing designs and colors, and bed covers gave the wards a gala appearance.

During the period of recuperation the children have the advantage of continuing their studies with teachers assigned by local boards of education. Sunrooms, well equipped playgrounds and playrooms and gardens are all part of the therapy practiced. Nurses and attendants are encouraged to keep the children amused.

#### SHRINERS BENEFIT, TOO

It isn't philanthropy solely for the patients, Mr. Kendrick points out. It is philanthropy for every Shriner in the sense of satisfaction he receives in giving not money alone but personal interest to the work. Some Temples have provided a transportation fund to help children get to the hospital. Members of the order are among the most frequent visitors, helping the boys with their stamp collections and providing entertainment and various recreational activities. Their wives and daughters contribute articles which bring hope and cheer to the young patient.

Hope and cheer! That is what these hospitals possess today. That is why, sitting in his Philadelphia office, the former mayor smiles reminiscently and proudly. How different from that first trip he made many years ago and the impressions he gained of seeing twisted and broken little bodies lying hopeless! To have had a share in transforming these "Homes for Incurables" to homes of hope and cheer! To have made it possible for others to share in the "world's greatest philanthropy"!

That is why, when asked about the future of the Shriners' Hospitals for Crippled Children in the overall planning of hospital care in this country, with talk of federal, state and city government participation and intervention in hospital and health affairs, Mr. Kendrick states simply and emphatically: "I feel that the Shriners' Hospitals for Crippled Children must go on independently with their contribution to humanity."

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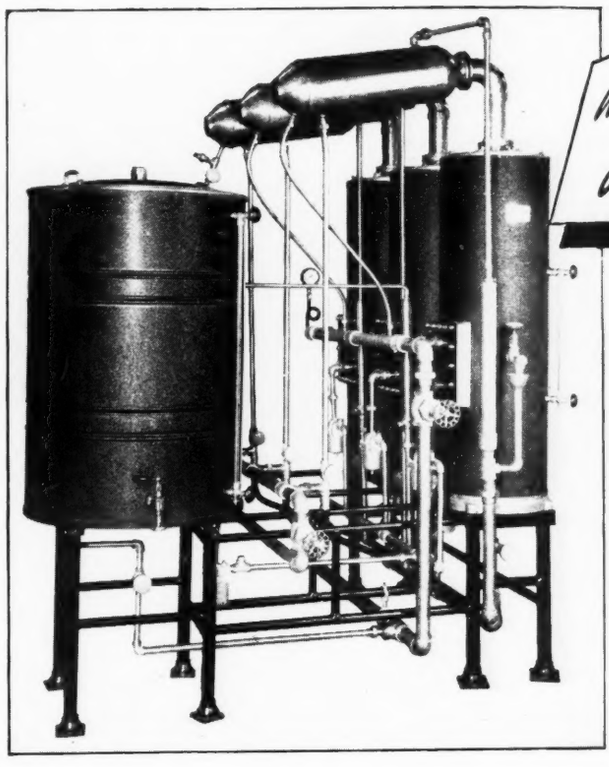

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# MEDICINE AND PHARMACY

## Minimal Pathology Committee

# SAFEGUARD AGAINST UNNECESSARY SURGERY

**FRANK M. DEALY, M.D.**
Mary Immaculate Hospital, Jamaica, N.Y.

ANY hospital serving the interests of the public has not only the right but the responsibility in the selection of its professional staff to assure itself, and through it the public, that the doctors to whom it extends the privilege of the use of its facilities are professionally competent and ethically sound. It has at least a moral obligation toward the patient, the recognition of which enables the person requiring hospital care to enter the institution confident that the treatment he will receive there will be in full accordance with accepted and established practice.

For this reason through its medical board, the hospital establishes its various services, draws up rules and regulations governing its professional staff, scrutinizes the qualifications of applicants, and in countless ways makes every effort to safeguard the interests of the patients it aims to serve.

### IMPROVEMENT STIMULATED

Through staff conferences, organized rounds, discussions, consultations and reports the professional work carried on is constantly assayed, and through its training programs constant improvement and progress are stimulated.

Despite all of these precautions, errors in judgment sometimes occur, accidents occasionally happen, but analysis of the causes, earnestly made, supplies the necessary correction and minimizes the likelihood of recurrence. Surgery always has its hazards but in the face of sound indications, necessary risks are freely assumed, and justifiably so, regardless of final outcome.

When risks are not necessary, however, or when proper indications are lacking; when the normal hazards of operative interference outweigh the need for surgical correction or when rational alternatives are not given proper consideration; when the existing disease condition is, in fact, minimal, surgical intervention cannot be justified. Under such circumstances operation is at best unwise: in cold fact it may well be judged unnecessary and no hospital can condone unnecessary operations.

One of the best stimuli for good surgery, as well as one of the best safeguards against unnecessary surgery, is the regulation whereby all surgical specimens obtained in the operating room automatically become the property of the pathological laboratory and without exception are sent there for examination. Accuracy of clinical diagnosis is thereby checked, extent of disease is determined, the basis for sound prognosis is broadened, and the necessity for operation is in many instances confirmed.

The receipt or accumulation of surgical specimens showing minimal disease, however, excites the suspicion that unnecessary procedures are being carried out.

When such a situation arose in our hospital (Mary Immaculate Hospital, Jamaica, N.Y.), not to an alarming degree but enough to disturb the ethical reactions of an alert pathologist, the matter was referred to the medical board which thereupon, in November 1946, appointed what came to be known as the minimal pathology committee.

This is a standing committee composed of five senior members of the staff representing the general surgical service, which in our hospital includes gynecology, urology and pathology. This committee meets as occasion requires, the pathologist submitting to it all of the surgical specimens which in his opinion show minimal disease. The charts, likewise, are made available so that all pertinent facts as brought out in the history, physical examination or laboratory findings and x-ray examinations may be considered in attempting to determine whether or not the operation seemed justified in view of the condition found.

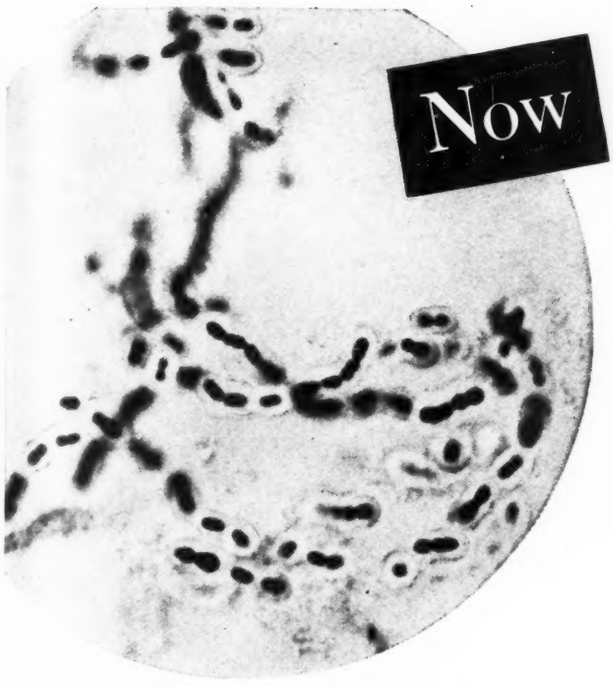
The additional information thus gathered from the chart may be such as to satisfy the committee as to the justification for operative interference. If so, the case is closed. If not, however, the decision is taken to interview the doctor concerned, whose name is then disclosed for the first time.

### BRING OUT MORE INFORMATION

Upon interview, the responsible surgeon may bring out additional information, not recorded in the chart, such as the opinions of consultants, previous unsuccessful attempts to overcome the difficulties with more conservative measures, x-ray pictures taken on the outside before admission, and thus make clear to the committee the validity of the indications even though the condition actually found was not in accordance with expectations.

If after interview, however, the committee concludes that the operative procedure was without justification, whatever action seems necessary is taken through the proper hospital authorities to correct the situation, even though this may require curtailment or complete withdrawal of the surgical privileges of the surgeon concerned.

The committee makes no detailed reports to the medical board, a report of "progress" usually being considered sufficient. Interviews, of course, are



*Photomicrograph of*
*DIPLOCOCCUS PNEUMONIAE*
*(magnified 1,350 times),*
after "typing" with homologous antiserum by Neufeld method. The swollen, unstained, sharply outlined capsules contain the type-specific polysaccharide, which is mixed with similar antigens from other types of pneumococci in the preparation of Solution of Pneumococcus Polysaccharides.

# Now *successful active type-specific immunization against pneumococcal pneumonia*

"The evidence . . . demonstrates clearly that immunization of man with the specific capsular polysaccharides of pneumococcus types I, II, V, and VII is effective in preventing the development of pneumonia due to these types in the immunized subjects."

MacLeod, C. M.; Hodges, R. G.; Heidelberger, M., and Bernhard, W. G.: J. Exp. Med. *82*:445 (Dec. 1) 1945.

In the above mentioned investigation on 17,035 subjects with a preparation made by Squibb, pneumonia of the types represented in the vaccine was entirely eliminated in the immunized group (8,586), excepting for four cases which developed before specific immunity had been established. And in the non-immunized group of 8,449 controls, all of whom were closely associated with the immunized group, the incidence of these types of pneumonia was *greatly lowered* through the reduction of "carriers." Reactions were mild. The slight arm soreness reported by those injected lasted only 3 to 4 days.

## *Solution of* PNEUMOCOCCUS POLYSACCHARIDES *Type-specific*

supplied in two combinations of types to which adults and children, respectively, are generally most susceptible:

COMBINATION A: Containing types 1, 2, 3, 5, 7 and 8. (Primarily for adults)

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DOSAGE: A *single* subcutaneous injection of 1 cc. for adults, or children over 12 years of age; 0.5 cc. for children under that age. Immunity usually develops within 6 to 9 days and is effective for at least one year.

AVAILABLE: Each combination supplied in 1 cc. and 5 cc. rubber-stoppered vials.

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private, but although the work of the committee is thus done with a minimum of publicity, the fact that it exists and that it functions is well known to the entire staff. This is a salutary feature of the entire setup, for with the assurance on the part of the staff that operative procedures that are not buttressed by adequate indications will be carefully investigated, the entire staff becomes more "pathology conscious," and every surgeon, including the most conscientious, takes added pains to see that the indications as brought out in a proper workup of the case and the disease actually demonstrable are adequate to justify his operative procedures.

The removal of an apparently normal appendix is not an altogether infrequent occurrence. In the so-called "chronic recurrent" case the morphologic changes may indeed be minimal, and still it is a fact, well known by all of us, that the indications are sometimes genuine and the results of its removal, gratifying.

#### NOT UNDULY ALARMING

Such a case, provided there is the recording of a thorough workup, with the elimination through proper study of other possibilities, does not unduly alarm the committee. Even the removal of a benign appendix, when one showing all the evidences of acute inflammation was anticipated, does not necessarily incriminate a surgeon in the minds of the committee either, for the committee definitely feels that, granted an honest approach, it is better to remove several such benign appendixes than to miss one that is a distinct, though perhaps hidden, surgical threat.

The fact remains, however, that the surgeon on our staff who has what might appear to be an undue number of chronic recurrent appendicitis cases for surgery, or who does a number of emergencies for what prove to be benign appendixes, will find himself before the committee at an earlier date than he who, unfortunately, occasionally has that experience.

Unnecessary hysterectomies for imaginary or insignificant disease were what originally instigated the appointment of this committee. It is gratifying to state that as a result of the investigation of these cases no similar ones have since been encountered.

One interview was held as the result of a nephrectomy for a supposed, though nonexistent, neoplasm. At that interview it became obvious, through the submission of additional information, that a thorough study had been made, that the indications for operation, if the patient were not to be deprived of what might well be his best chance, were sound, and that even with negative findings on exploration a nephrectomy was the procedure to be carried out. After the full presentation of this case, the member of the committee representing urology freely admitted that had the case been his own he would, under the circumstances, have felt obliged to carry out the same procedure.

The advantages arising from the functioning of such a committee may thus be seen to be many. Clinical records are more nearly complete and contain, besides all pertinent facts, information covering other aspects of the case, the results of previous examinations, the history, perhaps, of other types of therapy that previously proved inadequate, making clearer the status of the case and the indications for the contemplated surgical procedure.

The findings of the committee, moreover, may well be of value from the legal standpoint in the support of a member of the staff who, despite a thoroughly professional approach, carries out some operative procedure which as the result of subsequent findings on pathological examination proves, after all, to have been unnecessary.

In discovering those members of the staff who because of inadequate training exhibit poor judgment, or those who, perhaps lacking a keen sense of professional conduct, fail to be bound by sound indications, the committee serves a distinct purpose. In the one case, privileges may be more readily limited to capabilities and, in the other, the need for conforming to sound practice may be emphasized by their complete withdrawal.

The very existence of the committee apparently fulfills its purpose. The knowledge on the part of the professional staff that it has functioned, that it is a standing committee always ready to function, is in itself an adequate safeguard, serving the best interests of the doctors themselves, the hospital in which they work and, most of all, the patients seeking trustfully the professional care they have such a right to expect.

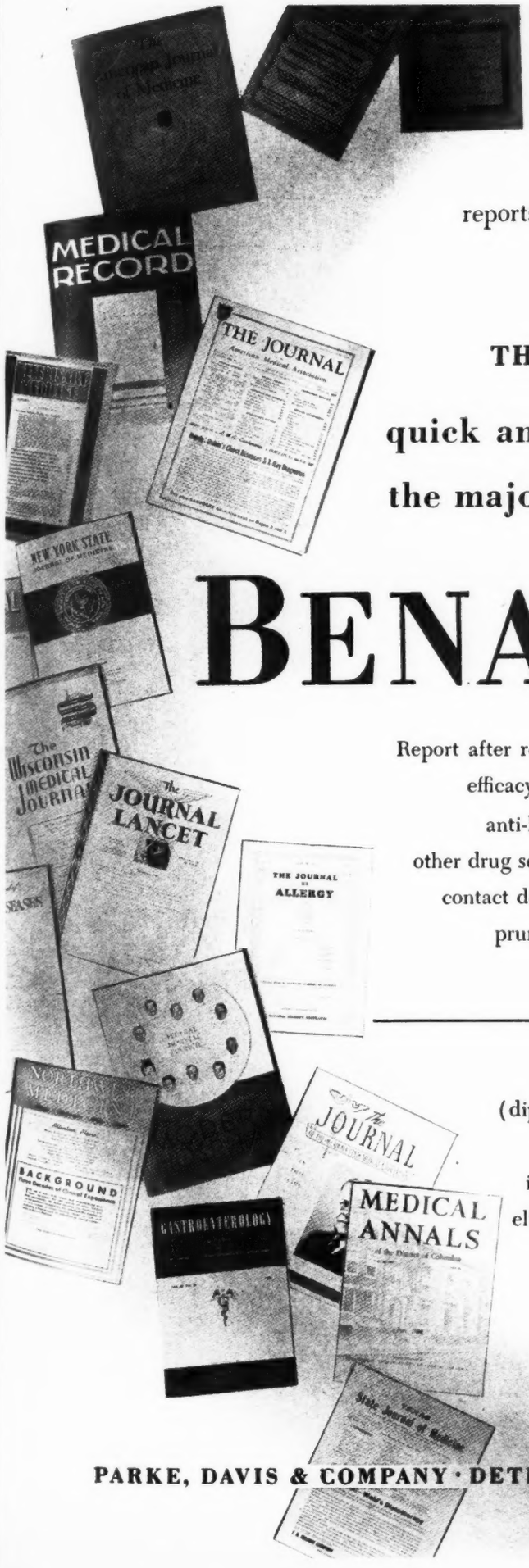
## EDUCATION FOR THE DEAF CHILD

IN AN article entitled "Educational Treatment of Deafness," the Lancet, Oct. 25, 1947, A. W. G. Ewing and Irene R. Ewing, of the department of education of the deaf, Manchester University, two of the world's outstanding workers in this field, outline their most recent work with deaf children. They now maintain that it is possible to develop speech comprehension through lip reading in children under 2½ years of age with the result that some of them make spontaneous attempts to talk. Training, they think, should be begun at the age of six months, or as soon as the deafness is discovered.

As part of a described experiment, thirty-two children between the ages of 12 weeks to 3 years were given home training by their parents under the guidance of the Ewings. In three cases, the children first developed the habit of watching for speech and then began spontaneously to lip read. All the children vocalized freely when they wanted something and in sixteen cases there were spontaneous attempts to say words in appropriate situations. The type of home training devised depended upon the degree of deafness.

New prosthetic equipment, improved hearing aids, including a visible speech apparatus (an electronic device by Bell Telephone Laboratories) and their use in auricular training are described, with particular emphasis upon increasing the hearing experience and thus rounding out the personality of the child.

Provisions are made in England, under public law, by the Ministry of Education for the training at public expense of all deaf and partially deaf children from 2 to 19 years. There is promise of a broader and more intensive program which includes a preschool, home or nursery program and a school program devised for various categories and classifications of the degree of deafness.—LAURA S. ROSENFELD.

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# NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics.
University of Illinois College of Medicine, Chicago 12

# SHOCK THERAPY IN MENTAL DISORDERS

## INSULIN SHOCK TREATMENT

THE observation of remarkable mental changes following severe hypoglycemic shock in certain cases of drug addiction led Sakel in 1933 to use insulin-induced severe hypoglycemic states as a treatment for psychoses. Usually, patients with acute schizophrenia and, occasionally, manic depressives or other psychotic or psychoneurotic patients are given this treatment.

Each patient must be given a thorough physical examination, including x-ray, electrocardiogram and laboratory studies, before treatment. When no neurological or vascular disease symptoms are manifest, a positive serological reaction is not a contraindication for shock treatment. Special instruction in the care of these patients must be given to the nurses who assist in the treatment. The patient must be continuously watched during the entire time of the treatment. The presence of a physician is mandatory during coma.

Delayed shock, which is the reappearance of hypoglycemic symptoms one or two hours after the patient has aroused completely, may also occur and should be anticipated. The patient must, therefore, be watched during the day of treatment and throughout the following night. Various drugs (ampules of caffeine, metrazol, coramine, strophantin, epinephrine, digifolin, atropine and dextrose 33-1/3 per cent in a 50 cc. ampule for intravenous use) should be immediately available.

The treatment procedure consists mainly of two phases, phase 1 (preparatory or preshock phase) and phase 2 (shock phase).

*Phase 1.* In this phase, the patient receives increasing doses of insulin. Six times a week, the insulin injection is given to the fasting patient (intramuscularly, into the gluteal muscle) early in the morning. Because there is a great variation in the response of the patients to insulin, therapy is started in each new case with a dose of from 10 to 15 units of ordinary (not protamine zinc) insulin. This dose is increased daily by 10 units until signs of hypoglycemia appear; the dose is then raised only five units daily. Usually, about one hour elapses between the injection and the appearance of symptoms of hypoglycemia.

Clinical manifestations observed in hypoglycemia are caused by changes in the metabolism of the body, especially of the nervous system. The symptoms of hypoglycemia usually show a definite progression, which results in characteristic changes in the sensorium, autonomic system, motor activity and reflexes of the patient.

The symptoms of hypoglycemia in the first hour are feeling of lassitude, somnolence, increased perspiration and increased salivation. In the second hour the symptoms become more marked, consciousness becomes clouded, drowsiness and sleep occur. A few patients show excitement.

Alterations of perception take place, spatial and time senses are impaired, illusions occur, disorientation, impairment of recent memory, aphasia, apraxia, clonic twitchings, tremor, atactic movements, tachycardia or bradycardia may be observed. This phase lasts until the so-called shock dose of insulin is reached. At this point, the daily insulin dosage is not further increased.

*Phase 2.* This phase is reached when the hypoglycemia is so marked that it produces loss of consciousness. Usually, that takes place in the third hour. In this stage, the patient responds either with coma or with a major convulsion. Shock or coma is considered as a state in which the patient does not respond to any attempt at arousal.

Sometimes, instead of the epileptiform seizure, a tetanoid seizure occurs which is not a desired result. As the coma deepens, the pupils dilate and will not respond to light, the pulse rate accelerates, cyanosis and labored respiration are present. Later the pupils contract and the corneal reflex disappears. The pulse rate is now slow (50 to 60 a minute). Periodic respiration of the Cheyne-Stokes or Kussmaul types may be seen. The disappearance of the corneal reflex indicates that the border of reversible changes has been reached.

This profound coma is usually reached in the fifth hour. The patient should be kept in coma for about fifteen minutes the first time. If no complications occur, the coma may be extended slowly up to an hour. The average coma dose is about 100 to 150 units of insulin but in some patients from 40 to 50 units will suffice.

*Technic of Recovery.* Hypoglycemia is terminated by giving an adequate

**Patients in New York Hospitals Treated With Insulin and Metrazol**

| | Recovered | Much Improved | Improved | Unimproved | Died |
|---|---|---|---|---|---|
| Insulin | 11.1% | 26.5% | 26.0% | 35.2% | 1.1% |
| Metrazol | 1.6% | 9.9% | 24.5% | 63.5% | 0.5% |
| Untreated Patients | 3.5% | 11.2% | 7.4% | 73.3% | 4.6% |

amount of carbohydrate (1) orally, (2) by nasal tube or (3) intravenously. As many grams of glucose (50 per cent solution) are given as the patient had units of insulin plus an additional 10 per cent of glucose. Patients who are able to swallow are given glucose orally, for instance, in phase 1 (from 4 to 4½ hours after the injection of insulin).

Patients who are in a semicomatose or comatose state should be given glucose by nasal tube or by intravenous injection of a 33-1/3 per cent dextrose solution. Adequate precautions must be taken during the insertion of the nasal tube and during withdrawal to prevent intratracheal instillation. Patients who are treated intravenously should be given additional glucose orally as soon as they can swallow.

If a patient does not respond after tube feeding and is not alert in about twenty minutes, an intravenous injection of glucose should be given. Shortly after glucose treatment the patient should receive a substantial breakfast.

Sometimes after apparent recovery an increase in hypoglycemic symptoms occurs. It is assumed that this is produced by a spontaneous output of body insulin resulting from stimulation by the sugar intake. The patient, therefore, must be kept in bed and watched closely for several hours after the administration of glucose. Usually the intravenous injection of from 20 to 30 cc. of a 33-1/3 per cent glucose solution is sufficient to treat delayed shock.

Insulin treatment should be continued as long as the patient shows mental improvement. An adequate trial consists of from 50 to 60 comas.

## METRAZOL CONVULSIVE THERAPY

Mueller had observed that spontaneous convulsions when they occurred in catatonic schizophrenia were sometimes followed by a prompt remission. As further evidence, Glaus and Steiner and Strauss had noted that epileptic seizures are extremely rare in schizophrenics. On the basis of these observations Meduna introduced pharmacologic convulsion therapy as treatment for schizophrenia in 1933 using camphor and later metrazol.

*Technic.* As with insulin shock, a thorough physical examination of the patient, including chest and spinal x-rays and an electrocardiogram, is required.

No sedatives are given to the patient for twelve hours because these drugs produce an elevation of the convulsive threshold. To avoid vomiting or aspiration of regurgitated material, the patient should not receive nourishment for several hours before the treatment. All foreign objects, including dental plates, are removed from the mouth. A pillow or sandbag is placed under the curvature of the mid-dorsal spine. A cylindrical mouth gag about 15 cm. long and 2 cm. in diameter is prepared for each patient. Ampules of coramine and caffeine and an oxygen tank with mask should be readily available.

The initial dose is from 3 to 5 cc. of a 10 per cent aqueous solution of metrazol, given rapidly intravenously. If no convulsion takes place within one minute, the injection is repeated with 1 cc. more than the original amount given. If again a seizure does not occur, the treatment is postponed twenty-four hours when treatment is initiated again with 1 cc. more than the last dose. This procedure is repeated daily until a seizure results. Some workers suggest 15 cc. as the maximum individual dosage. The fatal dose is probably about 30 cc.

As soon as the injection is complete, precautions against probable fractures and dislocations are taken. The convulsions start with wide opening of the mouth, at which moment the gag is inserted. The convulsion begins from 5 to 15 seconds after the injection and lasts from thirty to sixty seconds. The convulsion consists of an initial clonic phase, followed by a tonic and a second clonic one. The tonic phase shows the picture of decerebrate rigidity.

In the beginning of the seizure, the pupils dilate and become fixed during the ensuing convulsions; clonus of the foot and Babinski signs appear. At the end of the seizure, a period of apnea for several seconds sets in. The face is cyanotic, the eyeballs turned upward, a deep inspiration takes place at the end of the apnea, snoring-like respirations follow. After the seizures, the patient will doze or will show a state of psychomotor restlessness. The treatment is repeated after several days; at least two convulsions a week are recommended.

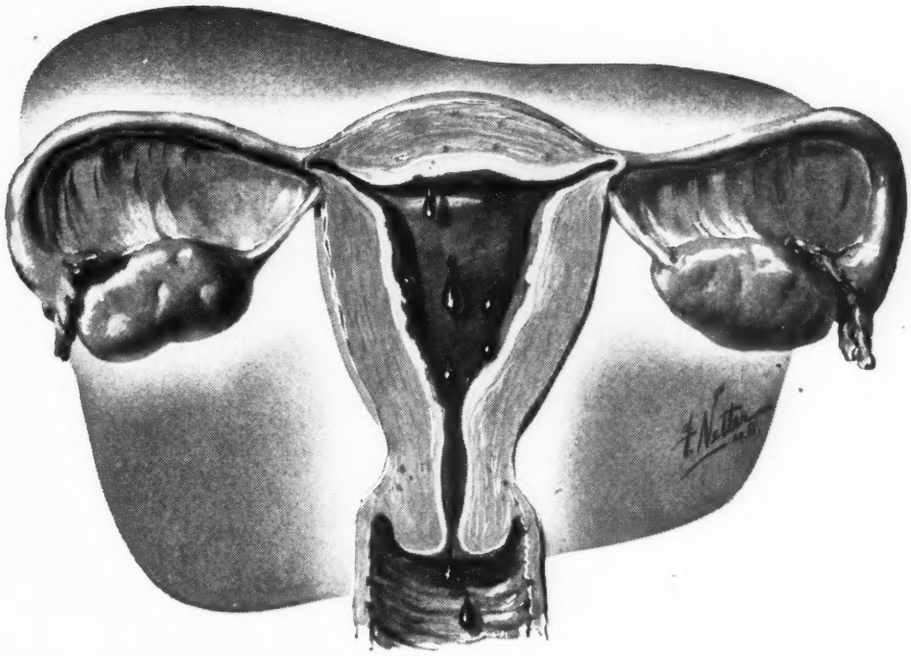
These may be continued to 25 convulsions before this mode of treatment is discarded. Others suggest discontinuing the treatment after the fifth seizure if no favorable change is seen and starting a new series of treatments after an interval of several weeks. The mode of beneficial action is not as yet known.

At the ninety-fifth annual meeting of the American Psychiatric Association (in May 1939) Ross and Malzberg presented the review of the results of the insulin and metrazol treatment of dementia praecox patients in New York State shown in the accompanying table.

## ELECTRIC SHOCK THERAPY

During the metrazol convulsive treatment, severe complications were encountered: the patients exhibited terrific fear and anxiety (immediately following the injection) prior to the loss of consciousness; not rarely, fractures of the vertebrae and other bones and severe cardiac strain were observed. Then, the Italians Carletti and Bini in 1937 replaced the chemical convulsive agents with the electric current. Preparation of the patient should, of course, include the procedures outlined previously.

*Technic.* Usually, an alternating current having a frequency of 60 cycles is employed in an electric control apparatus consisting of a voltmeter, a milliammeter and an automatic clock interrupter which times the duration of the stimulus. The patient is placed ly-



# Functional Uterine Flooding

Some years ago it was noted that the administration of some crude liver extracts for treatment of anemia in cases with excessive uterine bleeding produced a lessening of the flow. This led to the isolation of an active anti-menorrhagic factor from the sterols of the liver. Very good results have been obtained from the use of this ANTI-MENORRHAGIC FACTOR (ARMOUR) in the control of functional uterine bleeding. Such bleeding is most common in patients approaching the climacteric or during adolescence but it may occur at any age. Usually it is menorrhagic in type but may be intermenstrual or metrorrhagic. There may be complete irregularity in the menstrual function. ANTI-MENORRHAGIC FACTOR (ARMOUR) is recommended in all these varieties provided there is no underlying organic factor such as tumor.

During excessive flooding massive dosage may be indicated—8 or more glanules t. i. d., up to 50 per day. The most advantageous time to start treatment, however, is about two weeks before menstruation, giving 2 or more glanules t. i. d.

Literature upon request.

## Anti-Menorrhagic Factor

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ing face up on a table or bed with rigid surface. A gauze-covered electrode is fastened to each temple by a wide rubber band passing around the head.

The patient and those in contact with the patient should not be grounded in order to prevent deflection of the electric current from the path between the electrodes on the temples (also to avoid the danger resulting from deviation of the current through the heart). A rubber sheet beneath the under sheet on the bed is provided to insulate the patient. Other electrical instruments which are grounded should not be in contact with the patient.

A mouth gag is inserted prior to treatment. An attendant should hold the head in hyperextension on the bed and support the lower jaw to prevent dislocation. Other precautions are taken to avoid the possibilities of fractures, such as a pillow or sandbag beneath the dorsal or lumbar spine.

A convulsion is usually produced by the application of from 70 to 130 volts for 0.1 to 0.5 second with a milliamperage of from 200 to 1600. Sufficient current should be applied to induce a major convulsion. The seizure lasts for from thirty to forty-five seconds. The convulsion consists of three phases: a transient abrupt flexion throughout the whole body, a tonic phase (of ten seconds' duration) followed by a clonic phase (of from thirty to forty seconds' duration). Apnea and loss of consciousness occur during the convulsion.

The seizure is followed by coma of short duration from which the patient awakens in a confused state (with dizziness, nausea, headache and muscular pain); this state lasts about thirty minutes. Retrograde amnesia extending as far back as two hours before treatment has occasionally been observed. Post-convulsive procedures include mainly measures to restore the respiration, since the patient has been apneic during the convulsion. The pillow under the spine is removed, the head is turned to the side to allow saliva to drain from the mouth, and the jaw and tongue are held forward to prevent obstruction of the respiratory pathway. If the patient should not breathe, artificial respiration must be instituted immediately with carbogen (5 per cent carbon dioxide and 95 per cent oxygen).

In order to minimize the possibility of fractures, curare and sodium amytal are sometimes employed. However, the use of curare may cause respiratory embarrassment resulting from paralysis of the diaphragm. Neostigmin 1:2000, intravenously 1 cc., is administered in counteracting the curare effect. If respiration cannot be reestablished, artificial respiration should be instituted immediately and maintained until the curare has been detoxified and spontaneous breathing has been resumed.

Curare is contraindicated in patients with severe cardiac disease, acute pulmonary infection, thyrotoxicosis, thrombophlebitis and myasthenia gravis. Sodium amytal (300 mgm. of a fresh solution injected slowly intravenously, from 1 to 3 minutes prior to the induction of the convulsion) is sometimes used for the prevention of spinal and other fractures and for the treatment of postconvulsive excitement.

Electric shock is usually administered two or three times a week. The total number of treatments depends upon the patient's condition and response. The best results have been observed in the treatment of affective psychoses (depressive and manic states). In schizophrenics, better results are seen in patients who have been ill less than six months; in chronic cases favorable responses are reported in only a small percentage (8 per cent).

This treatment has been combined with insulin shock therapy. Electric shock is usually applied at the height of hypoglycemia. Sometimes, other electric shock procedures (with faradic or galvanic current) or shock treatment induced by nitrogen or carbon dioxide inhalations or vascular shock (produced by administration of acetylcholine or histamine) have been recommended. Not enough time has elapsed to determine the value of these shock forms.

## CONTRAINDICATIONS

Conditions which contraindicate the use of insulin, metrazol and electric shock therapy are: essential hypertension; angina pectoris (especially insulin); cardiovascular disease; thyrotoxicosis; tuberculosis; renal diseases; pancreatic disease; acute infections; bone atrophies; generalized osteoarthritis; thrombophlebitis (electric shock and metrazol); malignancies; head injuries or history of skull fracture (metrazol, electric shock); postoperative abdominal conditions with weakness of the abdominal musculature (electric shock); pregnancy (insulin, metrazol, electric shock); menstruation (insulin, metrazol, electric shock); cachexia (insulin, metrazol, electric shock).

## COMPLICATIONS

Some of the complications that may arise during shock therapy are as follows:

*Local irritations* (insulin): allergic reactions; urticaria; edema of the eyelids or glottis; anaphylactic shock (insulin: antihistamine drugs might be helpful).

*Cardiovascular disturbances* (insulin, metrazol): auricular fibrillation; acute myocardial failure (strophanthin is injected intravenously); circulatory collapse (caffeine, coramine, metrazol, strychnine are given); cardiac arrest (resulting from central vagus stimulation by electric shock treatment; atropine may be given prophylactically). In the event of any circulatory accident, recovery treatment in insulin therapy should be instituted immediately with intravenous glucose and each shock treatment should be interrupted.

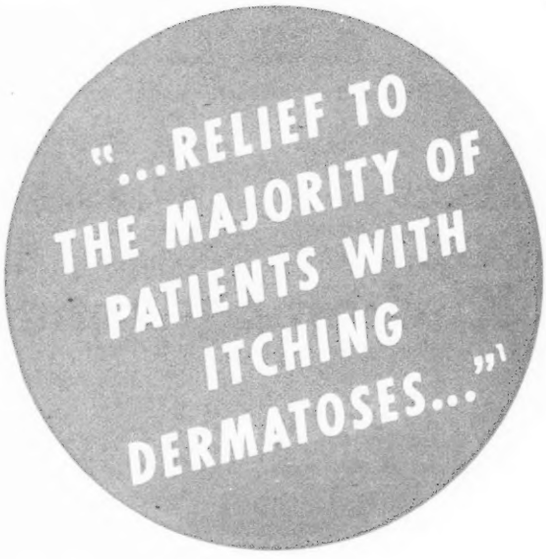
*Respiratory disturbances:* mucous obstruction, laryngospasm (insulin); postconvulsive apnea (electric shock); central respiratory failure (insulin: injection of metrazol; use of oxygen with carbon dioxide); pulmonary edema; pulmonary embolism; aspiration pneumonia; lung abscess (electric shock).

*Central nervous system disorders:* aphasia; hemiparesis (insulin); status epilepticus (insulin, metrazol, electric shock); subarachnoid or cerebral hemorrhage (insulin).

*Mental disturbances:* memory defects, hallucinations (insulin); Korsakoff's syndrome; reactivation of the psychosis or increase in psychotic manifestations (insulin, metrazol, electric shock).

*Vertebral fractures* (metrazol, electric shock); fractures of other bones (metrazol, electric shock); dislocation of the jaw or of the shoulder (metrazol, electric shock).

Most psychiatrists recommend that insulin, electric or metrazol shock therapy be administered only to hospitalized patients and only by psychiatrists who are trained in these treatment technics, and then only as an adjuvant in a total psychiatric treatment program.—ALFRED LEIMDORFER, M.D.

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1. Feinberg, S. M. and Bernstein, T. B.: Jl. of Am. Med. Assn. 134: 874, July 5, 1947

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# FOOD SERVICE

Conducted by Mary P. Huddleson

## THE FUNCTIONAL BASIS OF HOSPITAL PLANNING

# Kitchens and Kitchen Equipment

Continuing a Study by the
Division of Hospital Facilities
United States Public Health Service

A HOSPITAL is judged by its food. The recovery of the patient, in many cases and the reputation of the hospital are, in a large measure, dependent on nutritious, appetizing food with eye appeal. Such food cannot be prepared and served without an efficient kitchen and food service. These facilities can only be perfected by placing more emphasis on the kitchen plan, equipment and food distribution. The architect has much literature to guide him in designing the operating suite, nursery and patients' rooms; however, there is little specific information which can be applied to the special kitchen problems that are peculiar to each hospital plan.

### LOCATION

The kitchen should be located as near the center of the patient population as the hospital plan will permit to reduce to a minimum the average distance which food must be carried to the patients. The distance which the food must be carried vertically is not of so much importance because little time is required to move a food cart an additional floor in an elevator. The location of the kitchen will determine the type of food service, and for this reason the two should be considered at the same time.

When the kitchen is being planned, space should be provided for all related departments, including delivery entrance, storage, refrigeration, vegetable preparation, butcher shop, scullery, salad preparation, cooking, bakery food service, dietitian's office and special diets. The dietitian should be consulted relative to the arrangement and location of these departments. All departments, with the possible exception of the main storeroom, should be located at grade level to provide ample light and cross ventilation.

### PLANNING

The kitchen should be planned to provide straight line movement of the food from the service entrance through the preparation departments to the food carts or trays and to the elevators, without cross traffic.

The main storage room and refrigerators should preferably be located near the service entrance, with the preparation sections located near by, so that the raw foods and meat are available for processing without unnecessary cartage. The vegetable preparation section and butcher shop can often be placed on opposite sides of the refrigerators, with the doors of the boxes opening near their respective departments to avoid cross traffic. Each department must be a self contained unit with complete equipment, so arranged that the food can be prepared with the minimum handling and carting.

The cooking department, including ranges, fryers, ovens, kettles and steamers, should preferably be located near the center of the kitchen to permit the delivery of the raw foods and the removal of cooked foods without interference. The service tables and counters are arranged to receive the food from the cooking section and dispense it to trucks or to trays where central tray service is employed. The salad and dessert preparation and service should be in the same service area.

Baking for small hospitals is usually limited to small quantities and can be done satisfactorily in the ovens of the ranges or with a small oven located at the ranges. The larger hospitals may require a complete bakery, but as it is not related to the other kitchen departments it should preferably be located convenient to the storeroom and service section.

Special consideration must be given to the serving area and to space for washing and storing trucks. The serving area should be located as near the elevators or dumbwaiters as conditions will permit to reduce the time required to deliver hot food. Before the service area can be arranged, it must be determined whether there will be a central service, with trays set up in the kitchen, or whether the food will be sent to the patients' floors in bulk.

Small kitchens for the preparation of special diets have been used extensively in the past, but at the present time there is a tendency to use a sec-

tion of the main kitchen for this purpose. If a diet kitchen is provided, it is located near the serving area where facilities of the main kitchen can be used.

If dishes are to be returned to a central point for washing, the dishwashing room can best be located near the elevators and serving area. This location reduces the distance between the elevator and the dishwashing room and permits easy distribution of clean dishes to the trays. Dishes from the nurses', staff and employes' dining rooms are then washed in the same room. Where bulk food is delivered to the patients' floors, the dishes are usually washed on the floor but in some cases they are sent to the central dishwashing room.

### DELIVERY AND STORAGE

The delivery entrance should be located at a point where trucks and unloading will not disturb patients and should also be near the storeroom and refrigerators. Platform scales located in the receiving room, preferably of the depressed type, are necessary to check deliveries. The size of the storeroom varies with the buying policy, according to whether supplies are purchased wholesale or retail, and the quantities delivered at one time. Where large storerooms are required it is desirable to provide a small room adjoining the kitchen to which daily stores can be issued.

A single delivery entrance with one receiving clerk may be used for all hospital supplies, in which case provision must be made to store the foods separately and to dispense hospital supplies without passing through the kitchen. One way in which this can be accomplished is to arrange the basement under the kitchen for storage and deliver the hospital supplies through the basement to the elevators. With this arrangement, a lift is provided at the service entrance to deliver supplies to the basement and bring daily food requirements to the kitchen. Except as required by special conditions, the refrigerators should be on the first floor, as previously mentioned. With any storeroom an accurate check system for receipts and requisitions must be provided.

All storerooms for food must be constructed so that rats, mice and insects cannot enter and must be without spaces in which they can hide. Concrete or tile floors with fireproof plastered walls and ceilings provide proper protection. Metal shelving is preferable to wood; however, the design is as important as are the materials. The bottom shelf must be above the floor to permit inspection of all parts of the floor, and the top and ends should be set to provide space for cleaning and inspection. Walls and ceilings should be painted to permit easy cleaning.

The storage space for dry foods, vegetables and fruit must not be located under drain lines of the plumbing system inasmuch as small leaks or seepage from such pipes may contaminate the food supply. To maintain low temperatures in the storage space it is advisable to run steam and hot water pipes outside these spaces. Exposed pipes of any type are objectionable as they collect dust and often interfere with the shelving.

### VEGETABLE PREPARATION

If the potato parer is set near the entrance to the preparation space a very good plan can be developed. If the parer is mounted at the proper elevation adjacent to the vegetable sink it will discharge directly into a basket for rinsing, thus reducing the labor of handling. Potatoes can then be eyed and passed into the washing sink. One or two work tables and a food chopper, in addition to the equipment mentioned, will provide sufficient equipment for a hospital with a capacity up to 400 beds.

A cart with baskets can be used to advantage to bring potatoes to the parer and to fill the hopper without rehandling. An automatic electric shutoff or timing bell can be used with the parer to avoid removing too much potato with the skin.

### BUTCHER SHOP

For the butcher shop a chopping block, butchers' table and sink are required. The size can be varied to meet the requirements of hospitals up to 500 beds. A grinding machine and slicer will save both labor and meat. A fish box should be provided in this area, and it is often desirable to use a separate sink and preparation table for fish.

Consideration must be given to the use of frozen meat by providing for storage equipment for it or by allowing space for its future installation.

### RANGES AND OVENS

Ranges and ovens are heated by gas, electricity or coal. The use of coal should be avoided where possible as the heat cannot be accurately controlled, temperatures cannot be changed quickly, and the dirt and ashes are objectionable. When it is found necessary to use coal, the Swedish insulated type of range should be considered as it is economical in the use of coal, automatic in operation, and dissipates little heat to the kitchen. Gas heated equipment is generally used in hospitals. However, it is advisable to consult the gas and electrical utilities before reaching a decision on the type of fuel to be used. Electrically heated equipment has been highly developed and should be considered where low rates can be obtained.

The combination range with ovens will serve a 50 bed hospital for cooking, baking and roasting. However, there is now a tendency to use flat top ranges without ovens or storage space below, and separate ovens in battery with the ranges. This arrangement facilitates cleaning and makes the ovens more accessible. Bake ovens are placed with the roasting ovens unless a separate bakery is required.

The deep fat fryers and broilers are located with the ranges. The larger hospitals will require a broiler which can be set in battery with the ranges. Heavy duty institutional equipment should be used. This can be purchased in different sizes and types. It is available in stainless metal; however, the cost is approximately 100 per cent higher than that for standard units. All ovens and fryers should have adjustable thermostatic controls.

### KETTLES AND STEAMERS

Stock kettles of the steam jacketed type and low pressure vegetable steamers can usually be located to advantage back of the ranges and away from the walls. This arrangement permits circulation around the entire unit.

Stock kettles should be of aluminum or stainless metal, preferably mounted on a center pedestal leg. The spout must be removable or arranged to permit thorough cleaning of inside parts. To prevent the discharge of excess vapor from the kettles, vapor pipes with drips to the floor can be connected to the vent duct above the hood. It is customary to set the kettles in a depression in the floor which is pitched to a floor drain.

The steamers, which are usually located alongside of the kettles, are heated with steam at approximately 2 pounds' pressure; inasmuch as the

steam is released into the compartments with the vegetables it should be passed through an oil filter. The steam should be automatically controlled and a timer should be provided to prevent overcooking. Stainless metal linings and containers are furnished with standard equipment and are considered necessary. A three compartment steamer is the largest that should be used as the removal of containers from low or high compartments is inconvenient and dangerous.

### COOKS' TABLES

A table in front of the ranges is necessary for use by the cook. This table is usually furnished with bain-marie, deep sink, drawers, one open shelf and a pot rack at the ceiling. Heavy gauge stainless metal is preferable for the table top and sink. The bain-marie may be of copper or stainless metal, with a removable perforated stainless metal false bottom. An open shelf of stainless metal pipe is preferable.

Tables are desirable in front of the steamers and kettles. This location can also be used for the mixing machine. A pan rack should also be located in this area for use in connection with the ovens. The area occupied by the ranges, ovens, kettles and steamers requires ventilation, which can be obtained best with a hood. This hood should extend approximately 1 foot on all sides beyond the equipment and be constructed with a duct space to provide uniform exhaust. To avoid exposed horizontal surfaces which would collect dust and to conceal exhaust ducts, the four sides can be extended vertically to the ceiling. As the edges of the hood should be not more than 7 feet from the floor, some exhaust should be provided near the ceiling.

### SCULLERY

The scullery can be located in the main kitchen except in the largest hospitals, where a separate department is advisable. A deep two compartment sink with two drainboards is generally used; however, a three compartment sink is recommended. The first section is used for soaking, the second for washing, and the third for rinsing with 180° F. water.

### SALADS AND DESSERTS

The preparation areas for salads and desserts can usually be located together back of the serving counter. For these departments, preparation counters, cabinets and refrigerators are required. Double compartment sinks are necessary for both the salad and dessert preparation. The ice cream cabinet is also located in this area, although the ice cream should be prepared in another space.

### SERVICE AREA

The size of the service area will depend upon the type of service that will be used in the hospital. Central tray service requires greater space than does bulk food service because provision must be made for service counters and tray trucks. Food trucks for bulk service can be served directly from the kitchen equipment, but this cannot be done with central tray service.

The central tray service requires a service counter for the cold foods, desserts and hot dishes. The refrigerator for prepared salads can be set under the counter with tray slides to receive standard size trays; a separate refrigerator of the reach-in type will also be required. A steam table for meats, vegetables and soups is set into the hot section of the service counter, with a warming cabinet under the counter. A metal shelf above this counter is used for passing food.

The coffee urns, milk and coffee are usually located near the end of the service counter at a point convenient to the food trucks. An urn stand with drip pan, drain and water connections is required. A cup warmer is usually located under the urns. Should tray conveyers be used to carry the trays to the upper floors, the serving equipment is located along a movable belt so food can be served onto the tray as it moves toward the vertical conveyer.

The truck washing room or area should be provided with a floor drain and water connections. This space can also be used for the storage of trucks and for setting up trays. A cabinet and counter are also provided for tray service for condiments and dishes that may be required in making up the trays. The space used for the storage of electrically heated trucks should have base receptacles for preheating the trucks before they are loaded.

Steam tables of the water type have generally been used in the past. These consist of a water pan with steam coil, a false removable bottom and a cover with openings to receive the food containers. The objections which have been raised to this type are that all foods must be kept at the same temperature, and that excess heat and vapors are generated. The dry type of "steam tables" which are heated by electricity or gas is now being used to provide a different temperature for each section without vapor. Each section of the unit is furnished with an adjustable thermostat to maintain a constant predetermined temperature.

### DISHWASHING

With central tray service it is customary to return all dishes with the tray trucks to a central dishwashing room. There is a difference of opinion as to whether dishes should be washed on the different floors or at a central point. The determining factors are labor, breakage and effective washing and sterilization. Usually the number of employes available in a nursing unit is not sufficient to wash dishes, so the question is whether it is more economical to maintain additional employes for this purpose or to cart the dishes to a central dishwasher. The breakage is generally in proportion to the number of times the dishes are handled.

The first cost of a large central dishwashing room should be less than that of several small ones. In any case a large sized dishwashing room is required to serve the dining room and this need not be greatly enlarged to serve the entire hospital. With the usual equipment dishes can be cleaned and disinfected more effectively in the central dishwashing room than they can in the small units.

The dishes are first placed on the soiled dish table where they are dumped, scraped, rinsed and racked before being placed in the washer. This table is fitted with openings into which scrapings are dumped and a shallow sink or drain with perforated cover over which the dishes are rinsed with a foot controlled spray or hose. From the soiled dish table glasses and silver can be diverted to sinks or to a glass washer. Beyond the dishwasher

is a clean dish table, to permit the removal of dishes from racks and temporary storage. It is advisable to separate the soiled dish section from the clean one to prevent those who are handling soiled dishes from contaminating clean dishes.

The dishwasher should have at least two compartments, the first for washing and the second for rinsing. The water temperature in the second compartment should be maintained at 180° F. through the use of a booster heater if necessary. In some cases the racks of dishes go from the washer to a sink in which they are sterilized with water at 180° F. Some recommend, three compartment washers or two washers in tandem. The conveyer types of washers are recommended as they prevent the operator from passing racks through too rapidly.

Where racks are used, a roller type of gravity conveyer can be placed below the counter to return empty racks to the soiled dish table. To prevent contamination of the water supply system, the water connections must be made with an air gap, and the drain should be through a funnel.

Garbage grinders have been used successfully to dispose of garbage from the scraping table as they save considerable labor and are more sanitary than are garbage cans. They are located directly under the table openings and are connected to discharge through a drain to the sewer. Inasmuch as sanitary regulations in some localities prohibit the use of this equipment, this point should be checked before plans are prepared.

Separate facilities for washing and sterilizing dishes are required in communicable disease wards. Live steam jets are an effective and convenient means of sterilization. It is also recommended that dishes used by tuberculous patients and the hospital personnel be separated and be washed in different machines. In small hospitals, and where dishwashers are not used, three compartment sinks are recommended to permit the use of 180° F. water or a disinfecting solution in the third compartment.

### BAKERY

The extent of the work that is to be done by the bakery will determine its size and type. Where adequate commercial bakeries are available it is the usual practice to buy bread and staple pastries and bake only special pastries in the hospital. If no provision is made for baking bread, the space requirements are not so great. The equipment can be limited to a bakers' table with flour bins, mixer, refrigerator, hot plate, bakers' stove, trunnion kettle, oven, sink and storage cabinet.

### SPECIAL EQUIPMENT

Automatic egg cookers are considered a necessity in most kitchens. They should preferably be of stainless metal, mounted on the wall. Food choppers, grinders and small mixers and slicers can be used to save labor and food. Toasters, either gas or electric, are required. Small trunnion steam heated kettles can be used to advantage at several points in the kitchen for special diets, soups and desserts. In addition to the wash basins which are provided in the locker rooms, lavatories with elbow controls should be provided in the food preparation and cooking areas.

### SPECIAL DIET KITCHENS

Some hospitals, especially the smaller ones, prepare all special diets in the main kitchen. In such cases an alcove or a small area for limited equipment is adequate. The special diet kitchen is usually provided with a range, refrigerator, dresser, preparation counter with sink, pot sink, toaster, egg cooker, mixer and chopper. The main kitchen is normally depended upon for the preparation of many items used for special diets.

### CONSTRUCTION

All equipment should be designed, constructed and mounted to permit easy cleaning and to eliminate inaccessible spaces in which dirt can accumulate or which will harbor insects. Interior corners of the sinks should be rounded, and all seams and connections should be tight.

As far as conditions will permit, furniture and equipment should be set clear of walls. Where sinks or counters are placed against walls, a cleaning space of 4 or 5 inches should be left, or the fixture should be set into the wall and all joints cemented. To seal the space behind backs of sinks and drainboards it may be necessary to provide cover plates on the wall. Where possible, sinks should be wall hung, and waste and water pipes should be connected into the wall to leave the floor clear for cleaning.

Ranges, pedestals, floor cabinets and machinery should be grouted to the floor or set on concrete bases finished with tile covers to provide toe space. Space under all low shelves should be sufficient to permit easy inspection and cleaning. Stainless metals are recommended for sinks, table tops and counters as they are the most durable and sanitary materials and will reduce labor for cleaning and maintenance. Stainless metal legs and adjustable feet are also preferable. Spouts from kettles and all parts of equipment should be removable or arranged for easy inspection and cleaning.

### FROZEN FOODS

As frozen foods are being more generally used, consideration must be given to their storage, use and preparation. While some hospitals are planning to prepare and use cooked frozen foods which may be thawed and served in the pantry, the smaller institution need only make provision for the refrigeration and preparation of the frozen foods that are available commercially and can be used economically.

Quick thawing can best be accomplished with electronic heaters which generate the heat inside the frozen product. While several hours are required to thaw a gallon can of frozen eggs or fruit juice at room temperature, the same can may be thawed in a few minutes with an electronic oven without affecting the freshness of the product.

### DINING ROOMS

Cafeteria service is favored by most hospitals because it requires fewer kitchen employes. The cafeteria layout should be considered when the kitchen is planned. The cafeteria counter with tray slide is usually furnished with a cold counter with ice for salads, a steam table with plate warmer for meats, soups and vegetables, dessert racks and ice cream counter, and coffee and milk service. The back bar can be utilized for a refrigerator, short order stove, toaster and egg cooker.

Tray racks and silver trays are provided at one end of the counter and where a charge is made for meals the cashier can be located at the opposite end. Glass racks and cold water can be located at any convenient point. Glass shields with glass shelf are used to protect the food. To reduce the number of employes required to remove soiled dishes from the dining rooms, belt conveyers have been used which carry the dishes to the dishwashing table.

# Menus for March 1948

**Annalene Hemmer**
Billings Deaconess Hospital
Billings, Mont.

**1**
Orange Halves
Soft Cooked Eggs
•
Beef Stew With Peas, Carrots, Potatoes, Celery
Waldorf Salad
Cottage Pudding With Lemon Sauce
•
Cream of Tomato Soup
Crisp Bacon
Escalloped Corn
Lettuce Wedge With French Dressing
Canned Apricots

**2**
Tangerines
French Toast, Sirup
•
Meat Loaf
Escalloped Potatoes
Harvard Beets
Fruit Gelatin With Whipped Cream
•
Cream of Asparagus Soup
Crisp Bacon
Baked Potato
Tossed Green Salad
Canned Plums
Vanilla Wafers

**3**
Grapefruit Half
Scrambled Eggs
•
Roast Beef With Brown Gravy
Mashed Potatoes
Buttered Broccoli
Vanilla Ice Cream
•
Bouillon
Macaroni and Cheese
Lettuce and Tomato Salad
Baked Apple

**4**
Stewed Apricots
Sweet Rolls
•
Spanish Liver
Au Gratin Potatoes
Green Beans
Fresh Fruit Cup
•
Vegetable Beef Soup
Ham Salad
Potato Chips
Pickles
Chocolate Cake With Chocolate Icing

**5**
Stewed Prunes
Nut Muffins, Honey
•
Baked Salmon
Mashed Potatoes
Buttered Spinach
Cherry Cobbler
•
Oyster Stew
Combination Salad
Canned Pears
Cinnamon Rolls

**6**
Tomato Juice
Soft Cooked Eggs
•
Boiled Beef With Dumplings
Buttered Carrots
Apple Crisp
•
Beef Vgetable Soup
Spanish Rice
Pear and Cottage Cheese Salad
Pumpkin Cake With Pumpkin Icing

**7**
Sliced Bananas
Sweet Rolls
•
Roast Lamb With Mint Sauce
Mashed Potatoes
Buttered Peas
Relish Plate
Chocolate Ice Cream
•
Cream of Spinach Soup
Cold Cuts
Potato Salad
Canned Peaches
Oatmeal Cookies

**8**
Orange Halves
Scrambled Eggs
•
Veal Cutlets With Cream Gravy
Baked Potato
Brussels Sprouts
Cherry Cobbler
•
Tomato Bouillon
Meat Vegetable Pie With Baking Powder Biscuit Top
Lettuce Wedge With French Dressing
Frozen Apricots

**9**
Grapefruit Half
Soft Cooked Eggs
•
Chicken Chow Mein
Crisp Noodles
Combination Salad
Fruit Cup
•
Cream of Asparagus Soup
Tuna Salad
Potato Chips
Tomato Wedges
Gingerbread Apple Upside-Down Cake With Whipped Cream

**10**
Stewed Prunes
French Toast, Sirup
•
Pot Roast of Beef With Gravy
Parsley Buttered Potatoes
Baked Squash
Carrot and Celery Sticks
Rice Pudding With Raisins
•
Chicken Noodle Soup
Link Sausages
Escalloped Corn
Peach-Prune Salad
Baked Apple

**11**
Orange Halves
Sweet Rolls
•
Roast Leg of Veal With Gravy
Bread Dressing
Buttered Beets
Lemon Meringue
•
Beef Broth
Spaghetti With Italian Meat Balls
Tossed Green Salad
Gelatin Whip

**12**
Tangerines
Scrambled Eggs
•
Fried Halibut Steak, Tartare Sauce
Mashed Potatoes
Buttered Spinach
Maple Nut Ice Cream
•
Cream of Celery Soup
Crisp Bacon
Baked Potato
Sliced Pineapple Salad
Cinnamon Rolls

**13**
Sliced Bananas
Nut Muffins, Jelly
•
Meat Loaf With Mushroom Sauce
Escalloped Potatoes
Green Beans
Royal Anne Cherries
Sugar Wafers
•
Vegetable Beef Soup
Creamed Eggs on Toast
Tomato and Cottage Cheese Salad
Canned Apricots
Brownies

**14**
Orange Halves
Sweet Rolls
•
Grilled Steak
Baked Potato
Au Gratin Cauliflower
Relish Plate
Vanilla Ice Cream With Strawberry Topping
•
Beef Barley Soup
Cold Cuts
Macaroni Salad
Pickles and Olives
Butterscotch Pudding

**15**
Blended Juice
Soft Cooked Eggs
•
Breaded Liver
Mashed Potatoes
Creole Eggplant
Pumpkin Pie
•
Cream of Tomato Soup
Meat and Vegetable Pie With Biscuit Crust
Gingerale Salad
Baked Apple

**16**
Grapefruit Half
Scrambled Eggs
•
Boiled Chicken With Dumplings
Cranberry Sauce
Buttered Carrots
Strawberry Shortcake With Whipped Cream
•
Clam Chowder
Pea, Cheese, Pickle Relish Salad
Canned Peaches
Chocolate Cake With Boiled Icing

**17**
Stewed Prunes
Poached Eggs
•
Roast Beef With Gravy
Parsley Buttered Potatoes
Buttered Broccoli
Cloverleaf Rolls
Mint Ice Cream
•
Cream of Spinach Soup
Baked Stuffed Sweet Potato With Pork Sausage
Pear in Lime Gelatin Salad
White Cake With Mocha Icing

**18**
Tangerines
Blueberry Muffins, Honey
•
Veal Cutlets
Creamed Potatoes
Buttered Beets
Peach Cobbler
•
Consommé
Spaghetti With Meat Sauce
Tossed Vegetable Salad
Apple Crisp

**19**
Sliced Bananas
Soft Cooked Eggs
•
Grilled Halibut Steak, Lemon Slices
Escalloped Potatoes
Buttered Spinach
Glorified Rice Pudding
•
Cream of Pea Soup
Tuna Salad
Potato Chips
Canned Apricots
Oatmeal Cookies

**20**
Orange Halves
Scrambled Eggs
•
Beef Stew With Peas, Carrots, Potatoes, Celery
Waldorf Salad
Cherry Pie
•
Vegetable Beef Soup
Corn Fritters With Sirup
Crisp Bacon
Lettuce Wedge With French Dressing
Canned Plums
Wafers

**21**
Stewed Figs
Sweet Rolls
•
Baked Ham With Orange Sauce
Glazed Sweet Potatoes
Frozen Peas
Relish Plate
Vanilla Ice Cream
•
Tomato Soup
Cold Cuts
Potato Salad
Canned Pears
Ginger Cookies

**22**
Grapefruit Half
Soft Cooked Eggs
•
Swiss Steak
Mashed Potatoes
String Beans
Deep-Dish Apple Pie
•
Chicken Rice Soup
Beef Biscuit Roll With Brown Gravy
Tossed Vegetable Salad
Prune Whip

**23**
Sliced Bananas
Scrambled Eggs
•
Chicken à la King
Buttered Rice
Parsley Buttered Carrots
Fresh Fruit Cup
•
Celery Soup
Grilled Cheese Sandwich
Sliced Pineapple Salad
Coconut Cream Pudding

**24**
Tangerines
Nut Muffins, Jelly
•
Roast Leg of Lamb With Mint Sauce
Mashed Potatoes
Brussels Sprouts
Dinner Rolls
Chocolate Ice Cream
•
Beef Bouillon
Creamed Chipped Beef on Toast
Combination Salad
Frozen Apricots

**25**
Stewed Prunes
Sweet Rolls
•
Meat Loaf With Pea Sauce
Baked Potato
Harvard Beets
Peach Cobbler
•
Split Pea Soup
Escalloped Corn
Link Sausages
Lettuce Wedge With 1000 Island Dressing
Bing Cherries

**26**
Tomato Juice
Soft Cooked Eggs
•
Fillet of Sole With Tartare Sauce
Escalloped Potatoes
Buttered Spinach
Lemon Meringue
•
Oyster Stew
Macaroni Salad
Canned Plums
Cinnamon Rolls

**27**
Orange Halves
Cinnamon Toast
•
Fried Ham Steak
Parsley Buttered Potatoes
Baked Squash
Pineapple Upside-Down Cake With Whipped Cream
•
Potato Soup
Lettuce, Bacon and Tomato Sandwich
Canned Pears
Oatmeal Cookies

**28**
Grapefruit Half
Scrambled Eggs
•
Roast Beef With Gravy
Mashed Potatoes
Asparagus Tips
Relish Plate
Maple Nut Ice Cream
•
Vegetable Beef Soup
Cold Cuts
Baked Potato
Combination Salad
Chocolate Cake With Boiled Icing

**29**
Stewed Figs
Soft Cooked Eggs
•
Beef Stew With Peas, Celery, Carrots, Potatoes
Fruit Salad
Pumpkin Pie
•
Tomato Soup
Link Sausages
Escalloped Sweet Potatoes
Apple Casserole
Frozen Loganberries
Vanilla Wafers

**30**
Tangerines
Blueberry Muffins, Honey
•
Fricassee of Chicken
Cranberry Sauce
Mashed Potatoes
Buttered Broccoli
Fruit Cup
•
Consommé
Salmon Biscuit Roll With Mushroom Gravy
Pear and Cottage Cheese Salad
Butterscotch Pudding

**31** Stewed Prunes, Scrambled Eggs • Spanish Liver, Escalloped Potatoes, Parsley Buttered Carrots, Vanilla Ice Cream • Cream of Celery Soup, Ham Salad Sandwiches, Potato Chips, Baked Apple

Ready-to-eat or cooked cereals are offered on all breakfast menus.

# MAINTENANCE AND OPERATION

## PROPER AIR CONDITIONING IS ESSENTIAL

### to the health and comfort of infants in the nursery

**PAUL F. WOOLRICH**
Sanitary Engineering Staff
Texas State Department of Health, Austin

THE proper design of a nursery and its air conditioning equipment is essential to the health and well-being of all infants in that nursery. In the case of premature infants, life itself is dependent upon air conditioning specifications and standards which have been proved suitable. Arriving at suitable specifications and standards for the air conditioning of nurseries involves the study of facts and records gathered by hospitals, the American Hospital Association and the American College of Surgeons, the U.S. Children's Bureau, and engineering studies of the problem. By experience of all sorts and under varying conditions, these groups and others have arrived at the same general conclusion concerning the problem.

#### GENERAL CONSIDERATIONS

There are five principal factors determining the quality of the air and its effect on human comfort: temperature, humidity, movement, radiation and cleanliness.

*Air temperature,* technically known as "dry bulb" temperature, is usually measured by an ordinary glass thermometer which is not affected by the humidity of the air.

*Absolute humidity* is the number of pounds of water vapor carried by 1 pound of dry air. *Per cent absolute humidity* is the number of pounds of water vapor carried by 1 pound of dry air at a definite temperature, divided by the number of pounds of vapor that 1 pound of dry air would carry if it were saturated at the same temperature. *Relative humidity* is the ratio of the actual partial pressure of the water vapor in the air to the saturation pressure at the dry bulb temperature. For practical purposes, relative humidity is taken as the ratio of absolute humidity to the maximum amount of water vapor that a given volume of air will hold at the given dry bulb temperature, inasmuch as this ratio is approximately the same as the ratio of vapor pressures.

#### TEMPERATURE AND RELATIVE HUMIDITY

The U.S. Children's Bureau recommends a temperature of 80° F. and a relative humidity of 50 per cent for the infant nursery. At a relative humidity of 50 per cent the infant becomes cross with an increase in temperature and humidity.

Following birth, the premature infant's body temperature begins to recede so that he literally freezes to death at room temperature or temperatures at which full term babies are comfortable. For this reason higher temperature and greater relative humidity may be required by the premature infant. The purpose of air conditioning in this case is to stabilize the infant's body temperature.

Blackfen and Yaglou indicate that a relative humidity of about 65 per cent has considerably reduced the incidence of respiratory and gastrointestinal disease and improved the premature infant's chances for life. The requirements for temperature vary from 75° F. to 100° F., according to general constitution and body weight. The best air temperature for any infant was found to be the lowest that would stabilize the body temperature with a relative humidity of 65 per cent.

Complete conditioning of the hospital is recommended, for it has been observed in maternity hospitals which are not completely conditioned and cooled that there is some fear of reducing the nursery temperature much below the prevailing ward temperature, owing to sudden temperature contrasts in moving infants back and forth to their mothers for nursing. In many instances complete conditioning of a hospital is not financially feasible, in which case unit conditioners can be utilized in individual rooms, wards or nurseries. Units of this type which can be readily moved from room to room are obtainable if desired.

A single nursery conditioned to 77° F. temperature and 65 per cent relative humidity has been found to fulfill the requirements of the majority of premature infants until they attained a body weight of from 4 to 5 pounds. Some infants will require different conditions, which necessitates the use of heated beds or incubators in the conditioned nursery. In the case of the Dionne quintuplets, Dr. Dafoe of Callander, Ont., relates that as soon as incubators were available the temperature was kept between 87° F. and 90° F. at first with a gradual lowering to 84° F. Humidity in this case was provided by sponges soaked in hot water and placed in the incubators.

The main advantage of incubators is the complete isolation and protection of infants from contagion that is possible through their use, whereas

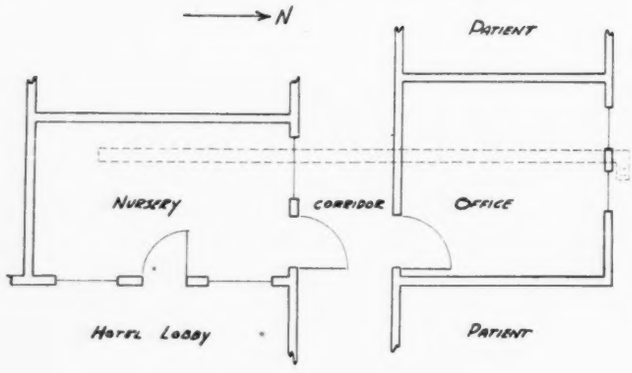



**Fig. 1. Nursery A located in a hotel is ventilated by a transom opened into the hotel lobby and an open window on the north side of the nursery. A ceiling fan provides air circulation in the room.**

their disadvantage lies in the increased cost of so many individual units.

A separate air conditioned nursery is desirable but if this is not to be had for the premature infants, proper environmental conditions can be obtained for them by the use of incubators.

### AIR VELOCITIES AND AIR CHANGES

Early specifications for from 15 to 25 air changes per hour have been proved harmful not only because they create drafts to which the infant is highly sensitive but also because they stir up dust-borne organisms from the floor of the nursery. It is generally contended that from eight to 12 changes per hour are consistent with odor removal and uniformity of temperature in extremes of weather. The *Guide* of the American Society of Heating and Ventilating Engineers stipulates an air movement of less than 20 f.p.m. in nurseries for premature infants. Fifteen f.p.m. air velocity is considered suitable for nurseries.

### CIRCULATION OF AIR

The circulation of air throughout the nursery should be guided by means of louvers, reflectors and other means to carry air to the nursery ceiling and out over the nursery so as to eliminate draft across the cribs of the infants.

Under no conditions should air be circulated into the nursery from other sections of the hospital owing to the danger of cross contamination of respiratory diseases from other sections of the hospital. A particular nursery may be cited to illustrate this point:

The nursery is located in an inside room of the hospital adjoining the hall on one side and the maternity ward on the other side. The room received no outside ventilation, the only ventilation received being through a transom above the door leading to the hall on the west and through a duct next to the floor on the east. In this case it is apparent that organisms of airborne diseases from other sections of the hospital can pass freely into the nursery by way of the hall.

Recirculation of air in hospitals should be done only under the most careful supervision to assure the complete removal of odors and air-borne contamination. Control of respiratory infection can be effected only by combining with air conditioning such other bactericidal means as ultraviolet light barriers or mechanical barriers. In the event the air (recirculated) is washed in water sprays prior to passage into cooling and conditioning equipment, there should be a frequent change in spray water.

### SPACE ALLOTMENT IN NURSERIES

With 200 cubic feet per infant and from eight to 10 air changes per hour, fecal odors are perceptible on entering the nursery but are not particularly objectionable. About 300 cubic feet per infant is recommended.

The U.S. Children's Bureau specifies 30 square feet and 300 cubic feet per "well" infant; for infants suspected of being ill, 40 square feet and 400 cubic feet per infant are recommended.

### EXAMPLES

Of course, no two sets of recommendations for improvement to hospital nurseries would be the same because existing conditions would vary. When the improvement deals with air conditioning, location and climate play a most important part in deciding upon the improvement to be made. Two examples of nurseries that do not meet the standards, along with the possible recommendations to correct them, might be given:

Nursery A is located on the ground floor of a hotel, the location being thus more a matter of necessity than desire on the part of the practicing doctors. This space allotted is not suitable for a hospital; however, it is expected that the hospital will be located here only until construction costs are more reasonable. This nursery (Fig. 1) is an inside room, flanked on the east by the hotel lobby and on the north by a hallway through which access is gained to all rooms.

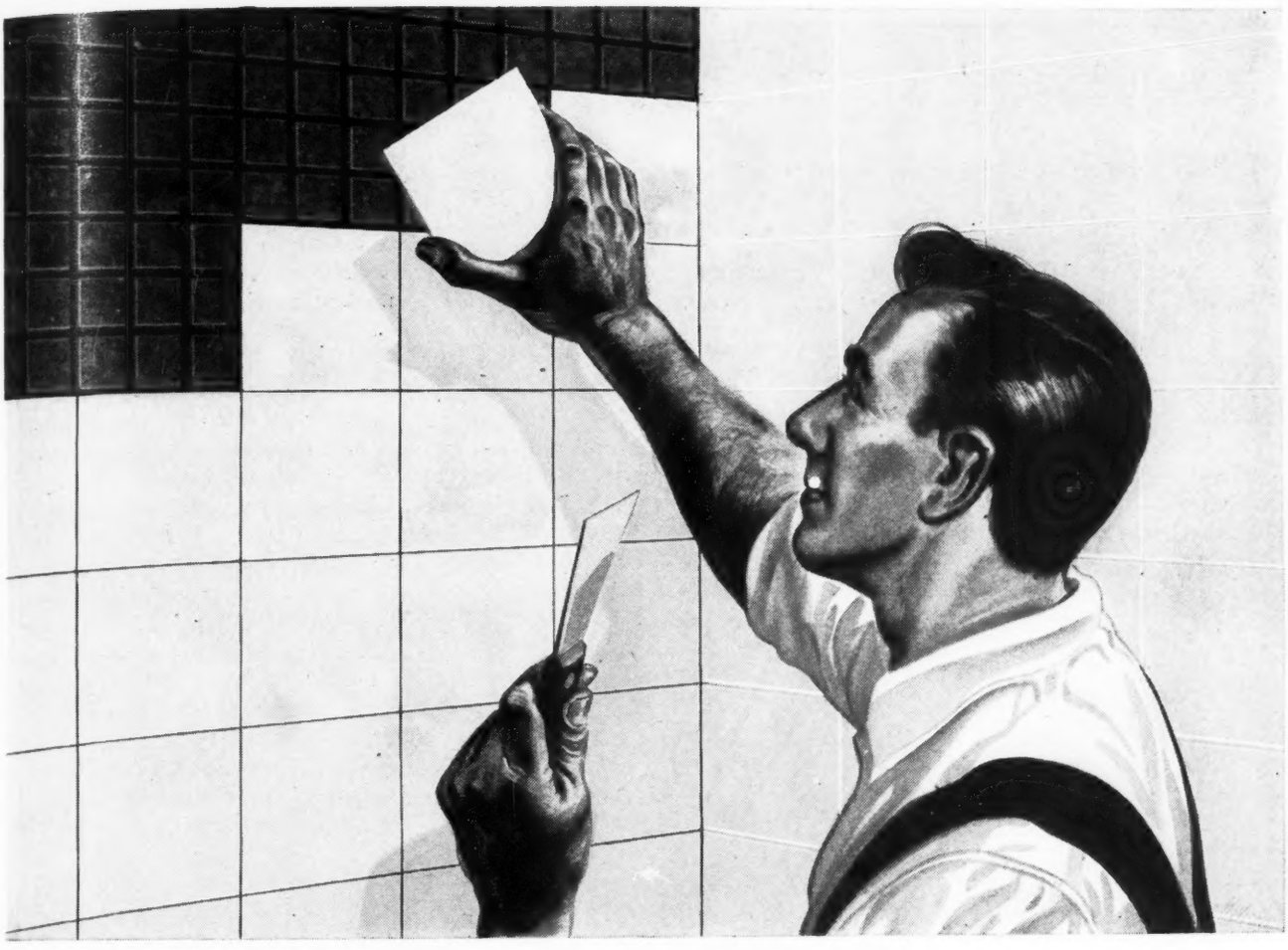
To provide ventilation for the infants within the nursery, a transom is opened into the hotel lobby and the window shown on the north side of the nursery is left open a few inches. A ceiling fan provides an air circulation within the room. Obviously, the existing ventilation facilities are highly inadequate from the standpoint of the babies' health. Under the circumstances, however, it is believed that the use of an inside room for the nursery can be justified provided adequate ventilation requirements are met.

### RECOMMENDATIONS

For nursery A the following recommendations might be made:

It is recommended that the ceiling fan be removed, the transom sealed and the window leading to the hallway on the north side be kept closed. To supply the necessary air for the nursery, a galvanized duct should be installed (Fig. 1) from the north side of the building into the nursery, approximately 10 feet. The duct should be 10 inches in diameter or 8½ by 9 inches to supply the 425 cubic feet of air per minute required. A small volume centrifugal fan, with a capacity of approximately 425 cubic feet per minute, fractional horsepower motor (1/20th to ⅛th horsepower if it can be obtained) to supply the air into the nursery against a static pressure of 0.62 inch of water is required.

To facilitate cleaning of the outside air, two 20 by 20 inch "throw away" filters may be installed in tandem with a spray of water between the filters. The spray water can probably be wasted into the sanitary sewer more economically than it can be recirculated. As indicated previously, the ducts should be carried approximately 10 feet inside the nursery to facilitate more uniform distribution of the air throughout the room. In order that the used air might be expelled from the room, the lower portion of the door leading to the hall on the north side of the nursery could be cut away and replaced by a grille. The positive pressure produced by the ventilation



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**ARMSTRONG'S VEOS WALL TILE**
Porcelain on Steel

system prevents cross infection from the hallway.

Ultraviolet light can be installed in the duct or path of circulating air to sterilize it. It is important that the ultraviolet light be shielded to prevent the infants' eyes from being exposed to the harmful rays. Radiant heaters could be installed on the south wall of the nursery in such a way that the fresh air from the duct would pass over them. This would take the chill from the air during the winter months.

The galvanized duct should be installed in such a way that a slope of 2 inches in 25 feet (approximately) toward the outside of the building is maintained. At some point in the duct a damper should be installed to regulate the flow of air as well as completely close the duct when necessary.

Nursery B is a small inside room (Fig. 2) bordered by a dining room, a hallway, an observation room and a kitchen. The size of the nursery limits its capacity to not more than three infants. Under existing conditions, ventilation is provided by means of an open transom through the hallway in which an ultraviolet light has been placed to sterilize the air. The total volume of the nursery is 503 cubic feet. With 12 complete air changes per hour, 100 cubic feet of fresh air per minute must be supplied from the outside.

To convey this quantity of air to the nursery an 8 inch circular duct, or a duct rectangular in cross section, 7½ by 7½ inches, should be used. The resistance of the duct, air filter and spray water which would be used in

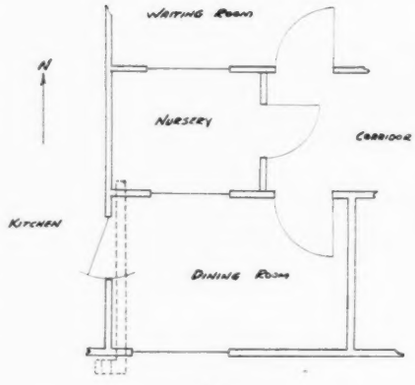



FIG. 2

**Fig. 2. Nursery B is a small inside room. Dotted lines show how outside duct should be installed to ventilate the area.**

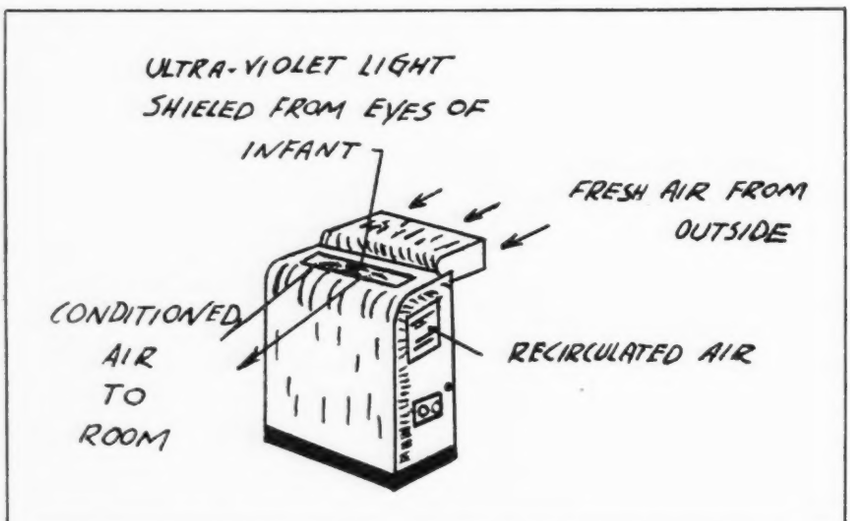
a system of this type would be approximately 0.6 inch of water. Using a centrifugal fan to supply 100 cubic feet of air per minute against a static pressure of 0.6 inch of water, an extremely small fractional horsepower motor (1/50th h.p.) is required, but again this is determined at present by what is available. The duct from the outside should be installed as indicated with dotted lines (Fig. 2) with a slight slope to the outside in order that condensed moisture will drain away from the nursery.

The lower portion of the door can be removed and replaced by a grille to facilitate exhaust of used air. The air should pass through tandem filters and a spray of water, the spray being located between the filters. The used water should be wasted.

Ultraviolet light should be installed at the duct outlet into the room to sterilize the incoming air. All necessary precautions to shield the eyes of the infants from ultraviolet exposure should be taken.

An alternate recommendation involves the relocation of the nursery to the present location of the dining room (Fig. 2). This would simplify the ventilating problem for a small air conditioning unit, provided temperature and humidity control could be installed, drawing the required air (100 cubic feet per minute) from the outside and the remaining would be recirculated within the nursery. If such a system were used, a means of sterilizing the air, using ultraviolet light, and heating the air in winter must be provided. Figure 3 illustrates this alternate recommendation.

The foregoing examples were given to illustrate what can be done in extremely small nurseries where it is generally not economically feasible to install a complete and expensive air conditioning system. In large nurseries where it is reasonable to expect complete air conditioning, heating, ventilating and air conditioning requirements can be determined according to the Standards in the same way.




**Conditioners can be obtained in which the condensing unit is disconnected when cooling is not needed, using only the fans to draw in outside air. A heating unit should be installed in fresh air inlet.**

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# HOUSEKEEPING Is Part of the Hospital

## So why not include executive housekeepers in national and regional hospital meetings?

**FLORENCE DUBOIS MOOERS**
Housekeeping Director, Sheppard and Enoch Pratt Hospital, Towson, Md.

IT IS a contradictory state of affairs when a recognized department of hospital administration is thought worthy, on the one hand, to share so much responsibility and, on the other hand, goes unrecognized when hospital associations convene. I refer to hospital housekeeping and the executive housekeeper.

Small wonder it is taking so long for educational standards for housekeepers to be set up and courses offered in our universities, or that hospital administrators search so hard for capable women to take charge of housekeeping departments, when planners of programs ignore the executive housekeepers. Probably some of the oversight is due to the executive housekeepers themselves; but most of it is not.

There are few, if any, regional associations where there could not be found executive housekeepers capable of organizing and presenting an interesting and educational program from which all department heads could learn much and doubtless are anxious to do so. In the few areas where the housekeepers have had a section meeting, the attendance of administrators and other department heads has been notable, and interest has run high.

Surely, it is not necessary to point out the advantages to be gained from such recognition and inclusion, for executive housekeepers are no different from other hospital department heads in their need to get together to discuss problems and hear new ideas presented in order that growth and betterment may ensue.

A by-product of one housekeepers' section meeting was the introduction of one speaker on the program to the field of executive housekeeping! She had thought of housekeeping in its relation to overall operating only, not realizing that in most institutions some woman was making a *job* of that activity.

Three area associations have invited executive housekeepers to have a section of their programs: the New England, the Maryland-District of Columbia and the Tri-State (Illinois, Indiana, Wisconsin and Michigan) hospital assemblies. The ice has now been broken in three widely spaced areas, and all program planners of future meetings have plenty of precedent for inviting the local or national president of the National Executive Housekeepers' Association to share in arranging the proposed programs.

Probably this form of recognition would do more than any other to dignify one of the most important fields of hospital management, a field of expanding usefulness as the importance of environment to patient and public is better understood.

Just as nursing and dietetics have moved from the purely practical to the professional status, so housekeeping is rapidly evolving in the same way through the aid of new and scientific approaches to the varied problems involved.

Recognition at all important gatherings of hospital management will speed the day when housekeeping will be able to keep pace with other fields of hospital endeavor.


# Air Conditioning

J-80056

# NEWS DIGEST

*College Approval for 3143 Hospitals . . . Magnuson Heads V.A. Medicine . . . Cahalane Resigns From Boston Blue Cross . . . Wortis Report Blisters Gallinger Setup . . . Project Applications Approved*

## A.C.S. Announces Approval of 3143 Hospitals in 1947 Survey

CHICAGO. — Administrators, trustees, medical staffs, and all other hospital personnel deserve the highest praise for the way hospitals are recovering from the effects of the greatest war in history, Dr. Irvin Abell, chairman of the board of regents of the American College of Surgeons, declared recently in announcing that 3143 hospitals in the United States and Canada qualified for approval following the thirtieth annual hospital survey completed December 31. Results of the survey were published in the December issue of the college *Bulletin*, issued last month.

"It is a satisfaction to state that, in general, the service rendered by our hospitals today, despite the high costs, shortages of personnel, and other difficulties which persist, is worthy of warm commendation," Dr. Abell added. "Numerically, the new approved list shows only a small increase of twenty-five hospitals over last year, which is partly because of the omission of some seventy-five United States Army hospitals which have ceased to operate. Of the 3900 hospitals under survey in 1947, 80.6 per cent are approved."

Dr. Malcolm T. MacEachern, associate director of the college, also commended the progress which hospitals are making and added: "Most hospitals are exercising strict control over surgery in the effort to prevent unnecessary operations. By firm policies and practices governing selection and restriction of privileges of the surgical staff, complete preoperative examination, consultation when indicated, comprehensive medical records on each patient, and critical review and analysis of clinical results by the entire medical staff, good surgery is assured.

"As the American College of Surgeons discovered when it began hospital standardization in 1917, progress in surgery depends upon progress in every aspect of hospital service. Hence the aim of standardization has always been to strengthen and improve the entire hospital. All elements involved in the care of the patient are considered in the surveys and in evaluation for approval."

## U.S.P.H.S. Reports Applications Approved Under Public Law 725

WASHINGTON, D.C.—Approved construction applications under Public Law 725 totaled 95 projects on January 16, the Hospital Facilities Division of the U.S. Public Health Service reported. Total cost of the approved projects was estimated at $42,089,342 with federal aid amounting to $13,810,372, the report said. A list of the approved projects follows.

| State and Project | Desc. | No. Beds | Ownership | Est. Tot. Cost | Est. Fed. Share |
|---|---|---|---|---|---|
| *ALABAMA* | | | | | |
| Chattahoochee Valley Hospital Langdale | Gen: P.H.C. O.P.D. | 82 | N.-P. | $1,663,287 | $552,633 |
| Jefferson County Health Dept. Birmingham | P.H.C. & Lab. | 0 | Pub. | 936,644 | 312,214 |
| "365" Crippled Children's Clinic Birmingham | Orth. | 100 | N.-P. | 1,701,105 | 502,435 |
| *FLORIDA* | | | | | |
| Gadsden County Hospital Quincy | Gen. | 60 | Pub. | 610,000 | 200,000 |
| Am. Legion Hospital for Crippled Children St. Petersburg | Orth. | 61 | N.-P. | 600,000 | 200,000 |
| *ILLINOIS* | | | | | |
| Good Samaritan Hospital Mt. Vernon | Gen. | 100 | N.-P. | 1,164,000 | 388,000 |
| Fairfield Memorial Hospital Fairfield | Gen. | 100 | N.-P. | 1,003,000 | 333,333 |
| Mt. Vernon Tuberculosis Sanatorium Mt. Vernon | T.B. | 200 | Pub. | 2,632,514 | 871,719 |
| Mercer County Hospital Aledo | Gen. | 50 | Pub. | 695,650 | 231,883 |
| Anna City Hospital Anna | Gen. | 50 | Pub. | 680,100 | 221,166 |
| Lawrence County Hospital Lawrenceville | Gen. & H.C. | 50 | N.-P. | 617,000 | 200,000 |
| Clay County Hospital Flora | Gen. | 50 | Pub. | 724,525 | 236,775 |
| *INDIANA* | | | | | |
| Washington County Memorial Hospital Salem | Gen. & H.C. Lab. | — | Pub. | 428,000 | 141,300 |
| Starke County Hospital Knox | Gen. | 35 | Pub. | 313,084 | 103,861 |
| Rush County Hospital Rushville | Gen.-O.P.D. and Lab. | — | Pub. | 616,000 | 200,000 |
| La Grange County Hospital La Grange | Gen. | 38 | Pub. | 442,500 | 142,500 |

(*Continued on Page* 120.)

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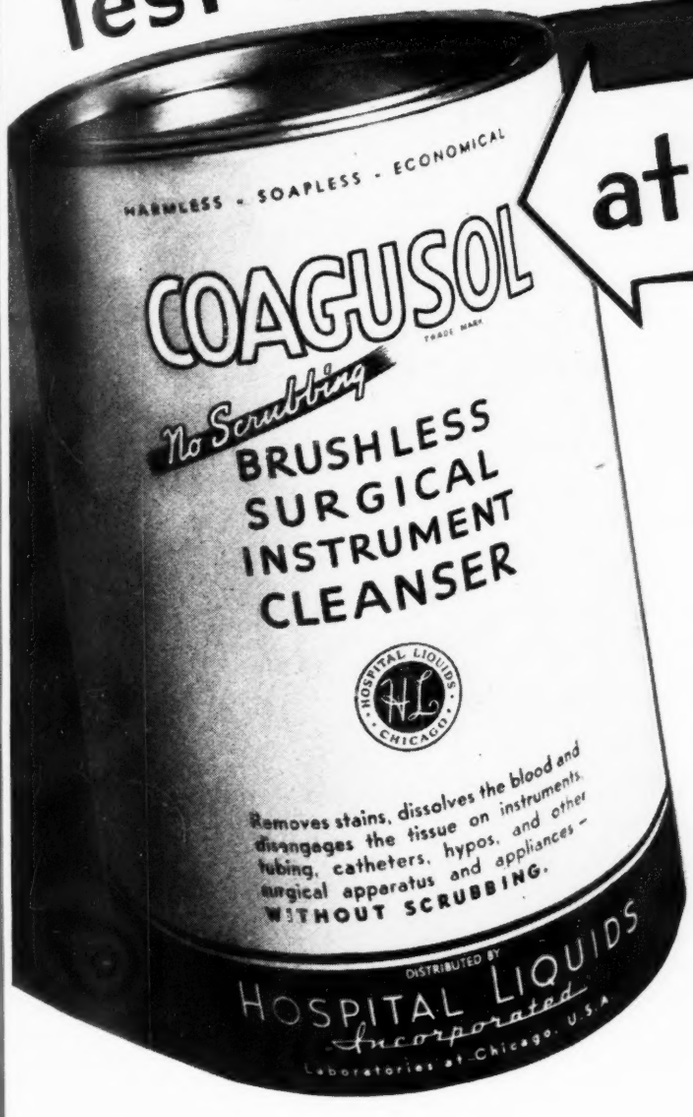


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# NEWS...

## A.M.A. Editorial Blasts Physicians Who Take Rebates, Commissions

CHICAGO.—In an editorial appearing in the January 17 issue of the *Journal of the American Medical Association*, the board of trustees of the A.M.A. calls upon leaders of the medical profession to act promptly in ridding the medical profession of physicians who accept rebates, kickbacks and commissions.

"The pride of medicine as a profession has always been its freedom from the taint of barter and trade in the sick patient," the *Journal* stated. "Physicians must give their wholehearted devotion to the care of the patient; no other objective must be given precedence over considerations of the patient's need. Nevertheless, the charge is made that some physicians have forgotten the ethical principles that prevail in the relationship between doctor and patient and have selected the surgeon willing to make the greatest division of fees rather than the one best suited to perform the operation. Ophthalmologists have sent the patient for lenses to the optician who returned a proportion of the fee rather than to the optician who rendered the highest quality of optical service.

### SOME ACCEPT COMMISSIONS

Occasionally, orthopedic surgeons and others who utilize the work of the maker of braces, splints and elastic bandages have been willing to accept commissions from such manufacturers and have delegated the procurement of these accessories to the agency offering the largest commission rather than to the one most painstaking in production and most reasonable in price. From time to time criticism has been leveled against pharmacists who have offered commissions to physicians on the prescriptions sent to them and to the physicians who have accepted such commissions. Wherever barter and trade have insinuated their insidious and evil aspects into the practice of medicine, the quality of the service has depreciated. The morals of the physicians and the commercial agencies that deal in these unwholesome profits in this marketing of medical care have already deteriorated.

"From the beginning of its entrance on the medical scene, the American

(*Continued on Page* 176.)

**PROJECT APPLICATIONS APPROVED BY U.S.P.H.S. (Cont.)**

| *State and Project* | *Desc.* | *No. Beds* | *Ownership* | *Est. Tot. Cost* | *Est. Fed. Share* |
|---|---|---|---|---|---|
| *INDIANA—Continued* | | | | | |
| Fountain County Memorial Hospital<br>Veedersburg | Gen. | 30 | Pub. | 415,700 | 136,933 |
| Whitley County Memorial Hospital<br>Columbia | Gen. | 57 | Pub. | 554,840 | 182,113 |
| Perry County Hospital<br>Cannelton | Gen. | 40 | Pub. | 500,000 | 166,000 |
| Tipton County Memorial Hospital<br>Tipton | Gen. & Lab. | 52 | Pub. | 624,000 | 206,000 |
| *KENTUCKY* | | | | | |
| Logan County Hospital<br>Russellville | Gen. | 50 | Pub. | 465,000 | 150,000 |
| Grayson County War Memorial Hospital<br>Leitchfield | Gen. & P.H.C. | 17 | Pub. | 230,000 | 75,000 |
| Nicholas County Hospital<br>Carlisle | Gen. & P.H.C. | 28 | Pub. | 305,000 | 100,000 |
| Casey County War Memorial<br>Liberty | Gen. & P.H.C. | 21 | Pub. | 230,000 | 75,000 |
| Garrard County Hospital<br>Lancaster | Gen. | 30 | Pub. | 267,500 | 87,500 |
| Allen County War Memorial Hospital<br>Scottsville | Gen. | 26 | Pub. | 225,000 | 75,000 |
| Owensboro-Davies County Hospital<br>Owensboro | Gen. | 48 | Pub. | 900,000 | 300,000 |
| Owen County Memorial Hospital<br>Owenton | Gen. | 21 | Pub. | 164,400 | 53,133 |
| *MISSISSIPPI* | | | | | |
| Leake County Memorial Hospital<br>Carthage | Gen. & N.H. | 50 | Pub. | 524,600 | 172,866 |
| Tippah County Hospital<br>Ripley | Gen. & N.H. | 40 | Pub. | 316,000 | 103,933 |
| Greene County Hospital<br>Leakesville | Gen. | 25 | Pub. | 239,900 | 77,300 |
| Choctaw County Hospital<br>Ackerman | Gen. | 23 | Pub. | 141,200 | 45,066 |
| Humphreys County Community Hospital<br>Belzoni | Gen. | 40 | Pub. | 281,000 | 90,000 |
| Clay County Health Center<br>West Point | P.H.C. | 0 | Pub. | 68,140 | 22,380 |
| Franklin County Health Center<br>Meadville | P.H.C. | 0 | Pub. | 45,000 | 15,000 |
| Marion County General Hospital<br>Columbia | Gen. | 80 | Pub. | 858,770 | 280,423 |
| North Sunflower County Hospital<br>Ruleville | Gen. | 30 | Pub. | 266,300 | 87,766 |
| Issaquena & Sharkey County H. C.<br>Rolling Fork | P.H.C. | 0 | Pub. | 37,632 | 12,544 |
| Kemper County Hospital<br>DeKalb | Gen. | 30 | Pub. | 240,000 | 78,666 |
| Winston County Public Health Center<br>Louisville | P.H.C. | 0 | Pub. | 1,164,000 | 388,000 |
| Copiah County Hospital<br>Hazlehurst | Gen. & N.H. | 50 | Pub. | 460,000 | 148,333 |
| Noxubee County Hospital<br>Macon | Gen. | 50 | Pub. | 498,100 | 161,866 |
| The Northeast Mississippi Hospital<br>Booneville | Gen. | 50 | Pub. | 600,000 | 195,500 |
| George County Hospital<br>Lucedale | Gen. | 30 | Pub. | 259,916 | 80,991 |
| Franklin County Hospital<br>Meadville | Gen. | 30 | Pub. | 250,000 | 83,400 |
| Rankin County Health Center<br>Brandon | P.H.C. | 0 | Pub. | 23,998 | 7,916 |
| Attala County Health Center<br>Kosciusko | P.H.C. | 0 | Pub. | 46,734 | 15,578 |
| Felix Long Memorial Hospital<br>Starkville | Gen. | 40 | N.-P. | 339,300 | 101,033 |
| *NEW MEXICO* | | | | | |
| Otero County Hospital<br>Alamogordo | Gen. | 26 | Pub. | 210,900 | 69,633 |
| Lincoln County Municipal Hospital<br>Carrizozo | Gen. | 25 | Pub. | 178,250 | 58,250 |
| Hondo Valley General Hospital<br>Ruidoso | Gen. | 15 | Pub. | 108,000 | 36,000 |
| *NORTH CAROLINA* | | | | | |
| Dare County Hospital<br>Manteo | Gen. | 15 | Pub. | 120,000 | 40,000 |
| Halifax County Community Clinic<br>Scotland Neck | Gen. | 20 | Pub. | 160,000 | 53,333 |

(*Continued on Page* 122.)


## "MY FINGER TIPS ARE OFTEN MY EYES"

Ask any surgeon what he wants in an operating glove and you'll get a definite answer:

(1) A glove that is *very thin** yet *very strong**—

(2) A gloveless glove—*uniformly thin*, even the *finger tips*—

(3) One that conforms to his hand—slips on easily—*after repeated sterilization.*

It is for these reasons that SEAMLESS is known everywhere as "THE GLOVE THE SURGEON HOPES TO GET".

3 TYPES: Brown Milled (banded)—White Latex—Brown Latex:

*FINEST QUALITY SINCE 1877*

SR REG. U. S. PAT. OFF.

# NEWS . . .

| State and Project | Desc. | No. Beds | Ownership | Est. Tot. Cost | Est. Fed. Share |
|---|---|---|---|---|---|
| *NORTH CAROLINA—Continued* | | | | | |
| Montgomery Memorial Hospital<br>Troy | Gen. | 40 | N.-P. | 480,000 | 160,000 |
| Scotland County Memorial Hospital<br>Laurinburg | Gen. | 100 | N.-P. | 1,200,000 | 400,000 |
| Sampson County Hospital<br>Clinton | Gen. | 100 | Pub. | 1,200,000 | 400,000 |
| Franklin County Hospital<br>Louisburg | Gen. | 50 | Pub. | 600,000 | 200,000 |
| Chatham County Hospital<br>Siler City | Gen. | 50 | N.-P. | 600,000 | 200,000 |
| Person County Memorial Hospital<br>Roxboro | Gen. | 60 | N.-P. | 724,250 | 240,000 |
| Stanly County Hospital<br>Albemarle | Gen. | 100 | N.-P. | 1,200,000 | 400,000 |
| Roanoke-Chowan Hospital<br>Ahoskie | Gen. & N.H. | 42 | N.-P. | 139,652 | 46,550 |
| *OKLAHOMA* | | | | | |
| Oklahoma State Health Department<br>Oklahoma City | H.D. Lab. | 0 | Pub. | 56,400 | 18,800 |
| Eastern Oklahoma Hospital<br>Vinita | T.B. | 30 | Pub. | 112,500 | 37,500 |
| Jackson County Hospital<br>Altus | Gen. | 55 | Pub. | 457,500 | 150,000 |
| Central State Hospital<br>Norman | T.B. | 50 | Pub. | 337,500 | 112,500 |
| Guymon City Hospital<br>Guymon | Gen. | 20 | Pub. | 178,000 | 59,266 |
| Hugo Memorial Hospital<br>Hugo | Gen. & H.C. | 32 | Pub. | 301,160 | 99,386 |
| Fairfax Municipal Hospital<br>Fairfax | Gen. | 16 | Pub. | 165,300 | 53,433 |
| Nowata Hospital Inc.<br>Nowata | Gen. | 30 | N.-P. | 115,450 | 36,816 |
| Okeene Municipal Hospital<br>Okeene | Gen. | 24 | Pub. | 201,000 | 62,000 |
| Cushing Municipal Hospital<br>Cushing | Gen. | 31 | Pub. | 316,495 | 105,498 |

(*Continued on page* 180.)



## Cahalane Resigns as Head of Massachusetts, National Blue Cross

BOSTON.—Reginald F. Cahalane, executive director of Massachusetts Blue Cross since its inception in 1937, resigned January 13, the Blue Cross board of directors announced. Mr. Cahalane also resigned as chairman of the national Blue Cross commission.

Mr. Cahalane's resignation followed a long period of conflict in Massachusetts Blue Cross, it was explained. Financial problems arising from the pressure of increased hospital costs have forced Blue Cross to use up more than a million dollars of its reserve funds during the last year, an official of the plan reported.

Recently, participating hospitals in the plan were offered a new contract under which a stated sum would be allowed for hospital board and room, and subscribers would pay the difference between this amount and the hospitals' regular charge for the service. The new contract also provided for a cash limitation on extra services, such as x-ray, it was explained.

Roger W. Hardy, a Boston attorney, who has been a member of the Blue Cross board, was named acting director following Mr. Cahalane's resignation.

J. D. Colman, executive director of Maryland Hospital Service, Baltimore, succeeds Mr. Cahalane as chairman of the Blue Cross commission. Mr. Colman was formerly the commission's vice president.

News reports that two hospitals in Massachusetts had served notice of their intention to withdraw from the Massachusetts Blue Cross Plan brought simultaneous statements from the president of the Hospital Association of Rhode Island and the executive director of Rhode Island Blue Cross indicating that harmonious relationships exist between the two organizations in this state.

Oliver G. Pratt, president of the hospital association, said, "We know from day to day contact that the Blue Cross is meeting the needs of the people here, and both the relationships with and the payments to the hospitals are sound." Stanley H. Saunders, executive director of Rhode Island Blue Cross, stressed the fact that each Blue Cross plan is separate and apart from all others, and that the action of the Massachusetts hospitals would have no effect on subscribers to the Rhode Island prepaid hospitalization plan.

# NEWS . . .

## Drs. Hawley and Magnuson Continue With V.A. Medicine

BY EVA ADAMS CROSS

WASHINGTON, D. C.—The first official act of Carl R. Gray Jr. upon becoming Administrator of Veterans Affairs was to name Dr. Paul R. Hawley as his special assistant. Dr. Hawley had just resigned as chief medical director.

On January 14 Dr. Paul B. Magnuson succeeded Dr. Hawley as chief medical director. He has been closely associated with Dr. Hawley in reorganizing the V.A.'s medical program for the last two years. The continued association of these two men ensures uninterrupted progress in the V.A. medical program.

At his first press conference, the new chief medical director paid a tribute to doctors, saying that as a group they come no finer. But he vigorously denounced certain private doctors suspected of taking advantage of a program by which they treat veterans and receive fees from the government. He has prepared a list of such suspects for the American Medical Association and has asked the association to clean its own house.

Dr. Magnuson would enter into no premature discussion of racial discrimination as practiced by some V.A. hospitals, according to one reporter's statement. He said all veterans received the same treatment from him—regardless of the color of their skin.

Dr. Magnuson also refused to get into what he termed a political discussion of where V.A. hospitals should be located. He said hospitals, no matter how fine the building or splendid the equipment, were no good without doctors and that they should be placed where doctors are available. He does favor, nevertheless, small well equipped hospitals in isolated communities if they are well staffed.

## President Again Urges National Health Program

WASHINGTON, D.C. — A national health program stood high among the goals President Truman listed in his January State of the Union message. The heart of the program must be a national system of payment for medical care based on well tried insurance principles, the Chief Executive insisted.

The President called for the extension of unemployment compensation and old-age and survivors' benefits to millions not now covered, and urged raising the level of benefits. The President also cited the recent report of his Committee on Civil Rights as pointing the way to corrective action by the federal government and by state and local governments of discrimination whether based on race, creed, color or land of origin.

## Open N. J. Consulting Office

CHICAGO.—Herman Smith, M.D., director of Michael Reese Hospital here for twenty-five years, and for the last year a hospital consultant with offices in Chicago, last month became associated with Otis N. Auer of Glen Ridge, N.J., it has been announced. Mr. Auer was assistant director of Michael Reese from 1925 to 1931 and was director of Monmouth Memorial Hospital, Long Branch, N.J., from 1941 to 1945.

*One basic change has*

# REVOLUTIONIZED ZEOLITE WATER SOFTENING


## *Here's what the new Elgin means to you-*

### *Most hospitals need more soft water—*

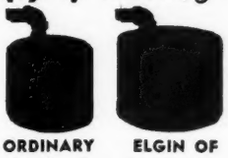
In hospitals, probably the number one use for soft water is in the laundry. But why stop there? In the boiler room soft water stops the scale and lime, cuts boiler cleaning and maintenance. In hot water piping and heaters it prevents hard water deposits, cutting maintenance and replacement costs. In sterilizers it prevents hard water damage, eliminates objectionable deposits on instruments. It makes dishwashing easy — assures clean, sparkling dishes and silver. Throughout the hospital it means easier cleaning, better cleaning, makes everything spic and span as it should look in a hospital. Soap and cleanser costs are cut in half. Remember: Elgin gives you this *extra* soft water at far lower cost per gallon!

*Where corrosion is a problem, Elgin anti-corrosion treatment gives complete protection.*

***Your present softener, regardless of make, can be modernized by Elgin to incorporate the features and advantages of the Elgin "Double-Check" Softener. The new bulletin explains this.***

***When*** we say the Elgin "Double-Check"* method has revolutionized the zeolite water softener, we simply state a fact that is confirmed by more than 3,000 of these softeners now in service. Users acclaim it; operating records confirm it! Here briefly is what the "Double-Check" Softener means to you:

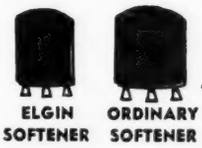
***(1) Up to 44% more soft water:*** By preventing escape of zeolite, the "Double-Check" manifold system permits utilizing a zeolite bed far deeper in proportion to the size of the softener. Likewise, by preventing escape of zeolite, a higher back-washing rate is made possible. The zeolite is kept clean and active, thus more zero-soft water is produced per pound of salt. For example, a 48″ x 72″ Elgin, softening ten-grain water, delivered 21,000 gallons more soft water per regeneration than a conventional softener of identical size.



ORDINARY SOFTENER — ELGIN OF SAME SIZE

***(2) Costs less****—to buy, operate, maintain.* Based on gallons delivered the initial cost of the Elgin is lower. The "Double-Check" distributing and collecting system means less regenerating salt and wash water. Elgin quality means longer life; lower maintenance.

***(3) Requires less space.*** The diagram tells it. This is often a vital consideration.



ELGIN SOFTENER — ORDINARY SOFTENER

***New bulletin*** *tells the convincing "Double-Check" story.* State whether you want the general power plant, laundry or hospital edition.

**ELGIN SOFTENER CORPORATION**

SOFTENERS ★ FILTERS ★ WATER TREATMENT ★ BOILER WATER CONDITIONING

# NEWS...

## Wortis Report Is Blistering Comment on Gallinger Division

WASHINGTON, D.C.—"What is needed is not another survey but direct action to correct this unhealthy and deplorable situation," said Dr. Samuel Bernard Wortis, U.S. Public Health Service consultant and director of Bellevue Psychiatric Hospital, New York City, in a report released on the psychopathic division of Gallinger Hospital.

"Another survey cannot substitute for adequate appropriations to correct these defects. Action at higher levels of responsibility is urgently needed," he added.

Previous surveys in 1938 and 1944 revealed many of the same conditions which Dr. Wortis called a disgrace to the city of Washington. Each year Gallinger officials have asked that the overburdened and inadequate facilities be corrected. Yet little has been done, according to this most recent report.

Specifically, Dr. Wortis claimed that the buildings of the psychopathic division are in a deplorable state; the equipment is archaic; the wards of the psychopathic hospital are drab, depressing and barn-like; the present plan does not provide for the necessary segregation of patients. The seniles, the alcoholics, prisoners, adolescents, children, medically and surgically ill patients, psychoneurotic and severely disturbed psychotic patients, all are thrown together. The staff is overworked and underpaid. Messengers, reception clerks and stenographers are needed. There is urgent need for more extensive cooperation between the medical and nursing staffs.

The entire staff of physicians, nurses and the personnel in the related services is doing a heroic job under terribly trying circumstances, Dr. Wortis commented. "It is physically impossible for five physicians and 74 nurses to do the work for which fifteen physicians and 113 nurses are needed," he went on to say. "I marvel that they are able to do as well as they do."

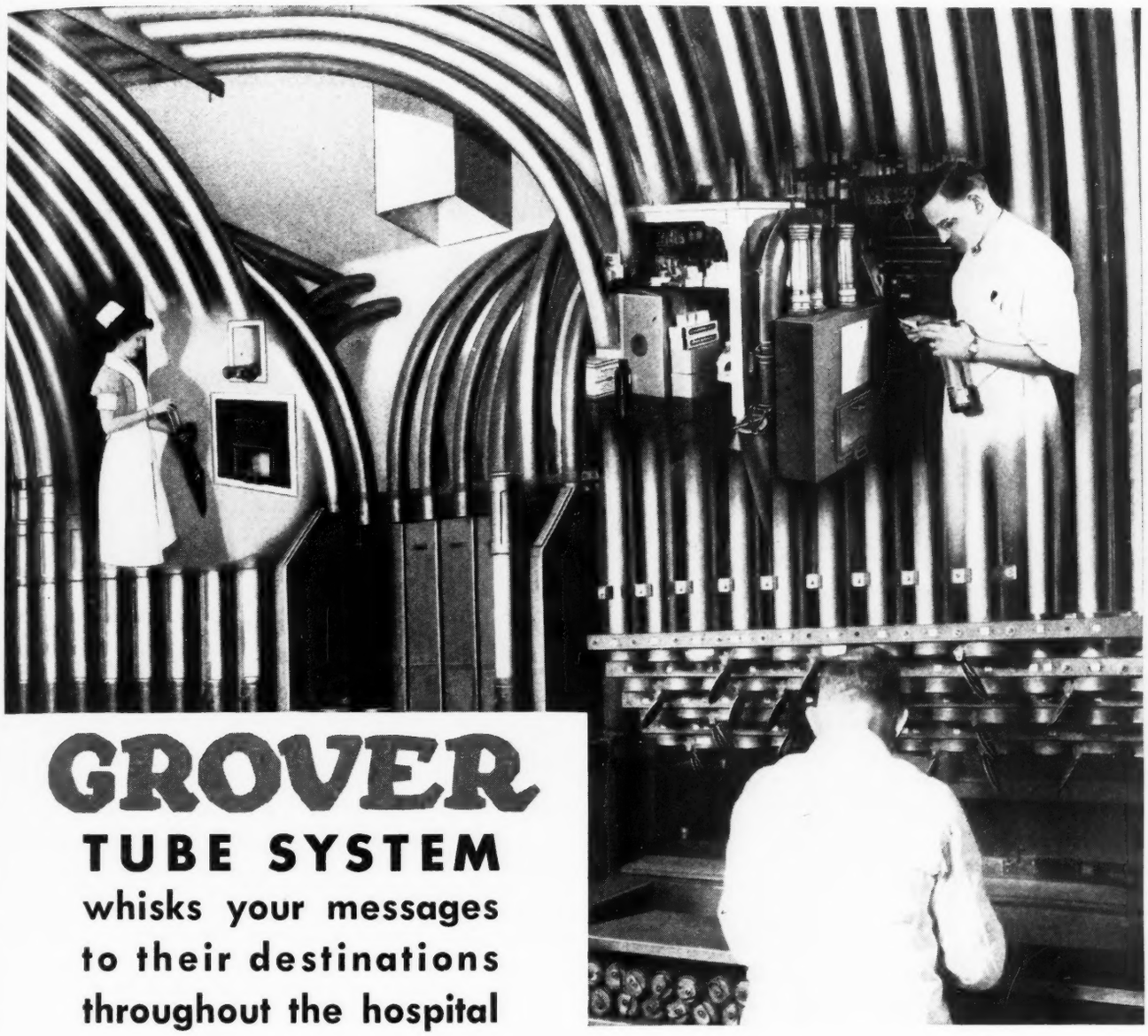
The District commissioners have announced that they will ask Congress for a $54,000 supplemental appropriation for psychiatric building improvements. Higher pay for Gallinger heads has been promised.

## Submit Project Applications Early, Hospitals Told

IOWA CITY, IOWA.—At the request of the Iowa Hospital Association, the state department of health recently issued an official statement urging hospitals seeking aid under Public Law 725 to complete plans and applications promptly even though their projects do not have high priority in the state hospital plan.

"Many of the areas holding a high priority may not be able to take advantage of their opportunity to receive federal aid," the statement explained, "because of high construction costs or other restrictive factors.

"For this reason, areas with a low priority and a definite proposal or project already adequately financed may find it desirable to submit applications early," the statement said, "in the hope that the department will find it necessary to go through many areas before reaching a sufficient number of qualified applicants in any one allotment period."



# GROVER
## TUBE SYSTEM
### whisks your messages to their destinations throughout the hospital

with


Here's a messenger that shoots swiftly and silently about the hospital on the thousand urgent or routine errands of the day—never makes a mistake, never dallies, never takes a day off, never has to be hunted up when wanted. Slip your message into the GROVER Carrier, drop it into the tube and in a flash it's at its destination—in another department, on another floor, in another building. Case histories, diet sheets, prescriptions, pharmacy requisitions, accounting information, small items and instruments, all kinds of communications are handled with speed, accuracy, privacy, silence—and with economy unequalled in any other method. Hospitals large and small use this excellent system to enhance efficiency and reduce costs. Any GROVER representative can tell you how and will be glad to consult with you on your specific objectives. No obligation, of course. Call any GROVER office or write for our Hospital Bulletin.


**GROVER** PNEUMATIC TUBE SYSTEMS
THE GROVER COMPANY
DETROIT 19, MICH.
*Offices in Principal Cities*

# NEWS...

## Veterans Can Benefit Under Only One Program at a Time

WASHINGTON, D.C.—World War II veterans are ineligible for training under the G.I. bill or the Vocational Rehabilitation Act while they are taking training in certain courses financed by other federal appropriations, Veterans Administration ruled January 21.

Certain courses financed by the government are available to veterans as well as to other persons. These are separate from the training programs established for eligible veterans under P.L. 16 and the G.I. bill. Among such courses are:

1. U.S. Public Health training programs for persons receiving fellowships or salaries from state and other grant-in-aid funds derived wholly from federal appropriations.
2. U.S. Maritime Commission training programs.
3. Resident training programs in hospitals, clinics, medical or dental laboratories owned or operated by the U.S. government.
4. Residency training for physicians and dentists in V.A.'s department of medicine and surgery.

The restrictions do not apply to veterans enrolled under either law in V.A.'s training program for clinical psychologists. These trainees may receive subsistence allowances based on the training provided them in educational institutions. They may be paid from government funds for part time work in V.A. stations where neuropsychiatric veterans are treated.

When veterans complete their training under other federally supported programs, they become eligible to continue their studies or take other training under provisions of the G.I. bill or P.L. 16.

## Forum on Legal Problems

WASHINGTON, D.C. — District of Columbia doctors got expert advice on legal problems that they may encounter in their practice in a medical-legal session held January 14. The program included an analysis of privileged communications by U.S. Attorney George Morris Fay and by Daniel J. Anderson, attorney. Coroner A. Magruder MacDonald took up the legal aspects of postmortem examinations.

# NEWS . . .

## Morristown Hospital Reports Result of Poll Regarding Service

MORRISTOWN, N.J. — Believing that patients themselves are the most important people concerned with services rendered by the hospital, Morristown Memorial Hospital has just concluded a poll of opinions from 1196 patients hospitalized there during the last twelve months from this and neighboring communities.

Patients' opinions are obtained from a printed questionnaire given to every patient just before he leaves the hospital. The questions listed have been carefully prepared so the patient is not influenced in the direction of either favorable or unfavorable comment but feels free to say exactly what he thinks about the services he has received. He is offered an envelope in which he may seal his questionnaire and forward it for the special attention of anyone in authority whom he may select. Also, he may fill in the form and forward it anonymously either before or after he leaves the hospital.

One year of experience with the questionnaires has just been completed, and all the returns have been reviewed by an agency outside the hospital. That agency reports briefly as follows on the 1196 questionnaires filled in during the year:

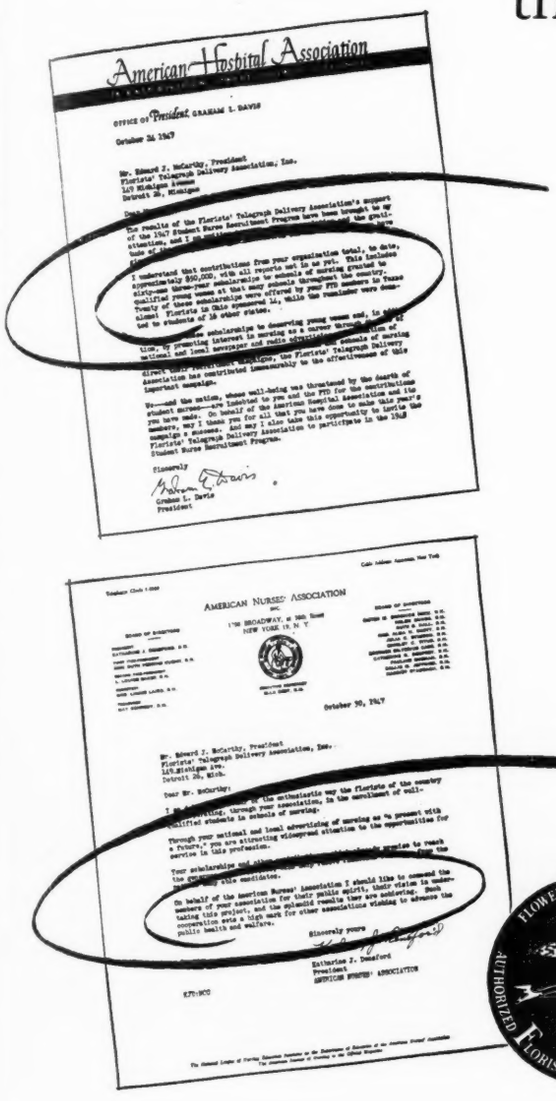
| | *Patients Satisfied* | *Patients Dissatisfied* |
|---|---|---|
| Reception ..... | 1192 | 4 |
| Nursing Care .... | 1195 | 1 |
| Food ..... | 1175 | 21 |

Excluding children and other patients incapable of filling in the questionnaire, approximately 50 per cent of the patients took advantage of the opportunity. Memorial Hospital authorities feel this is a surprisingly large number, in view of the fact that great care is taken to keep the canvass on a purely voluntary basis, and patients are merely handed the forms without any personal interview or pressure of any kind to persuade them to fill in the forms.

"The factual nature of the information obtained through the questionnaires was exemplified by the comments on the nursing care," a report of the results stated. "There were no definitely adverse comments of this kind, although quite a number of patients noted that the nursing coverage was too thin. All the comments about scarcity of nurses fell in periods when the hospital was exceptionally short of nurses. It was apparent that during the short handed periods the nurses on duty consistently overworked themselves and thus, with the remarkably few exceptions cited, were able to maintain Memorial's high standards of nursing service. As a matter of fact, this extreme loyalty and willingness to go far beyond the normal call of duty on the part of all the groups staffing Morristown Memorial is the one thing that has enabled the institution to maintain its high standards of service despite the personnel and supply shortages of the war and postwar years.

"Patients had a great deal to say about the food, which always seems to be a specially touchy subject among the sick. Of the twenty-one who were not satisfied, nine said that food that should

# F.T.D. is proud to receive your thanks for helping recruit Student Nurses



American Hospital Association

OFFICE OF President GRAHAM L. DAVIS

October 24 1947

Mr. Edward J. McCarthy, President
Florists' Telegraph Delivery Association, Inc.
149 Michigan Avenue
Detroit 26, Michigan

Dear Mr. McCarthy:

The results of the Florists' Telegraph Delivery Association's support of the 1947 Student Nurse Recruitment Program have been brought to my attention, and I am pleased to learn that the goal [illegible]

I understand that contributions from your organization total, to date, approximately $50,000, with all reports not in as yet. This includes sixty-one three-year scholarships to schools of nursing granted to qualified young women at that many schools throughout the country. Twenty of these scholarships were offered by your FTD members in France alone. Florists in [illegible] states, [illegible] to students of 18 other states.

[illegible] scholarships to deserving young women and, in [illegible] time, by promoting interest in nursing as a career through [illegible] of national and local newspaper and radio advertising, schools of nursing [illegible] Florists' Telegraph Delivery Association has contributed immeasurably to the effectiveness of this important campaign.

We—and the nation, whose well-being was threatened by the dearth of student nurses—are indebted to you and the FTD for the contributions you have made. On behalf of the American Hospital Association and its members, may I thank you for all that you have done to make this year's campaign a success. And may I also take this opportunity to invite the Florists' Telegraph Delivery Association to participate in the 1948 Student Nurse Recruitment Program.

Sincerely

Graham L. Davis
President



AMERICAN NURSES' ASSOCIATION
INC.
1790 BROADWAY, at 60th Street
NEW YORK 19, N. Y.

October 30, 1947

Mr. Edward J. McCarthy, President
Florists' Telegraph Delivery Association, Inc.
149 Michigan Ave.
Detroit 26, Mich.

Dear Mr. McCarthy:

[illegible] the enthusiastic way the florists of the country [illegible] through your association, in the enrollment of well-qualified students in schools of nursing.

Through your national and local advertising of nursing as "a present with a future," you are attracting widespread attention to the opportunities for service in this profession.

Your scholarships [illegible] from the Chapters who contributed.

On behalf of the American Nurses' Association I should like to commend the members of your association for their public spirit, their vision in undertaking this project, and the splendid results they are achieving. Such cooperation sets a high mark for other associations wishing to advance the public health and welfare.

Sincerely yours

Katherine J. Densford
President
AMERICAN NURSES' ASSOCIATION

KJD:MCG

• *Orchids to Mr. Davis for writing such a heart-warming letter! Permit us to quote this excerpt:*

"I understand that contributions from your organization total, to date, approximately $50,000, with all reports not in as yet. This includes sixty-one three-year scholarships . . ."

• *Orchids to Miss Densford for her kind words! This sentence makes us feel good:*

"On behalf of the American Nurses' Association I should like to commend members of your Association for their public spirit, their vision in undertaking this project, and the splendid results they are achieving."

**Yes,** the 7,200 F.T.D. florists in the U.S. and Canada have long been aware of the critical scarcity of Registered Nurses. We realize that this lack of trained personnel poses a disturbing problem for both hospital management and the present-day corps of nurses. To help resolve this problem, we have actively supported the Student Nurse Recruitment Program. Results have been gratifying. A forward step has been taken.

☆ ☆ ☆

We take this opportunity, in turn, to express our sincere thanks to executive and professional hospital personnel, for their cooperation with our deliveries of Flowers by Wire to patients.


*This advertisement, contributed by the Florists' Telegraph Delivery Association, ran in the July 5, 1947 issue of the Saturday Evening Post. In addition, scores more like it appeared in local city newspapers, sponsored by F.T.D. members.*

**FLORISTS' TELEGRAPH DELIVERY INTERNATIONAL,** 149 Michigan Avenue, Detroit 26, Michigan

have been hot was served cold. The remaining twelve reported the food to be unappetizing. An additional hot food cart was purchased as a result of the first group of comments, and certain serving arrangements were changed. Since these changes, there have been practically no adverse comments about hot and cold food. Not much could be done about the second group as it was found that most of the patients in this group had to be kept on special diets because of their illnesses."

Authorities at Morristown Memorial Hospital started the questionnaire as an experiment but are so satisfied with the constructive results of the first year's experience that they plan to continue the patient poll permanently.

## A.C.H.A. Plans Seven Institutes During 1948

CHICAGO.—The American College of Hospital Administrators in cooperation with various associated organizations and universities has scheduled seven institutes for hospital administrators to be held within the next few months.

They are: University of Minnesota, February 2-7, Minneapolis; Duke University, March 22-27, Durham, N.C.; Baylor University, April 19-24, Dallas, Tex.; Princeton University, May 17-22, Princeton, N.J.; University of Colorado, July 26-31, Boulder, Colo.; Columbia University, June 14-25, New York City; University of Chicago, September 6-18.

Lecturers will be drawn from the faculties of the universities and from the field. The institutes will be open to administrators and assistant administrators of approved hospitals.

## Committee on Isotope Distribution Formed

WASHINGTON, D.C. — Appointment of a new advisory committee on isotope distribution was announced January 12 by the Atomic Energy Commission. The committee will recommend policies governing isotope distribution and will review existing policies from time to time.

The interim advisory committee on isotope distribution policy and its two subcommittees on human applications and on allocation resigned at the end of 1947. The interim committee and its subcommittees were appointed by Maj. Gen. Leslie R. Groves of the Manhattan Project.

Dr. G. Failla of the Columbia University Medical School is chairman of the recently appointed committee.

## Colonelcy Given to Emma E. Vogel

WASHINGTON, D.C.—Maj. Emma E. Vogel, chief of the new Women's Medical Specialist Corps, has recently been made a colonel. One of three women colonels in the army, she now has supervision of three hitherto separate divisions of the medical department: dietetics, physical therapy and occupational therapy.

The Legion of Merit was bestowed on Col. Vogel in World War II for outstanding service in the medical department and for contributions made in her professional field in cooperation with the Council on Medical Education and Hospitals of the American Medical Association and the American Physiotherapy Association.

# NEWS . . .

## Philadelphia Plan Okays 6 per Cent Rise in Hospital Payments

PHILADELPHIA.—A 6 per cent supplementary payment to Blue Cross member hospitals for contract benefits has been authorized by vote of the Associated Hospital Service of Philadelphia, following conferences with the Blue Cross committee of the Hospital Council of Philadelphia, in which the recent increases in hospital costs were discussed.

"This action by Blue Cross," said Erwin A. Stuebner, chairman, Hospital Council of Philadelphia, "is greatly appreciated by the Hospital Council.

"The council is continuing its efforts to establish a subscriber contract and a payment formula which will recognize differences in costs and financial needs among our various member-hospitals. In this task, the hospital council is represented by its Blue Cross committee, which is working closely with the council's advisory board and the trustees and management of the Philadelphia Blue Cross."

## Provident Hospital Campaign Launched

CHICAGO.—A campaign for $500,000 to expand the Provident Hospital and nurses' training school was opened here last month. Provident Hospital treats 90 per cent of Chicago's Negro patients and trains a large number of the nation's Negro physicians and nurses, hospital officials said.

Of the amount needed, $100,000 will be used to meet the hospital's annual operating deficit, it was explained. New operating rooms, x-ray equipment, and other facilities totaling $200,000 are also required. Albert F. Hunt, vice president of Swift & Co., is general chairman of the campaign.

## Science Foundation Bill

A National Science Foundation bill was dropped in the House hopper by Congressman Priest early in January. The foundation would have 24 members appointed by the President, by and with the advice and consent of the Senate. The foundation would elect biennially from its own membership an executive committee composed of nine members.

# NEWS...

## Says More Advance Planning of Public Works Is Needed

WASHINGTON, D.C. — "We need more advance planning to assure an orderly flow of public construction," warned Maj. Gen. Philip B. Fleming, Federal Works Administrator, in a recent letter to President Truman.

"We need hospitals, highways, schools, airports, water systems, sewer systems and many other facilities," the administrator enumerated. Construction requirements for new state and local public works form a huge accumulation.

The finest kind of insurance to take care of this backlog of construction requirements and to guard against haste and waste was the Advance Planning Program under Title V of the War Mobilization and Reconversion Act of 1944, said Gen. Fleming. But the authority to make these advances lapsed with the expiration of Title V on last June 30. Now, the gap between promise and performance, between recognized needs and completed plans is dangerously wide, he pointed out.

Every public works official knows well that it may take from six months to two years to bring proposals to the point where actual construction begins, Gen. Fleming explained.

With the vast backlog of work needing to be done, replenishment of the shelf of plans is exceedingly important, Gen. Fleming urged as long ago as last July before a Senate committee on public works. Bills that would restore this opportunity are now pending in Congress, Senator Green's S. 1423 and Mr. Muhlenberg's H. 3490. The bills ask an annual appropriation of $50,000,000 to remain available for the advances until the end of the fiscal year for which the appropriation is made.



## Propose Program for Training Practical Nurses in Tennessee

CHATTANOOGA, TENN.—A proposed program for training practical nurses in Tennessee was outlined for members of the Tennessee Hospital Association by Nina E. Wootton, R.N. The course will be conducted in public schools by local boards of education, Miss Wootton said, in accordance with standards established by the state board for vocational education. Schools may also be established by individual hospitals which have the approval of the state committee on nursing education and nursing practice.

Training is designed "to produce persons trained to help meet community nursing needs in institutions and homes where the registered, professional nurse is not needed for continued service," Miss Wootton said. The practical nurse activities are limited to care of subacute, convalescent and chronic patients, well children, and the aged, under the direction of a licensed physician or registered nurse, it was explained.

Classroom instruction as outlined covers such subjects as elementary bedside nursing, food preparation, working relations, personal health, mother and child care, home management, and care of the aged and chronically ill. The practice field includes twenty-six weeks of hospital training in general medical, surgical, obstetrical and pediatric nursing.

# NEWS . . .

## Chicago Blue Cross Proposes Hospital Payment Change

CHICAGO.—Blue Cross Plan for Hospital Care has proposed a plan under which members may be offered the opportunity of keeping present comprehensive service contracts at an increased subscription rate or continuing subscription payments at the present rate and accepting a rider providing for payment of $1.50 a day at the time of hospitalization. This amount would be paid by the patient directly to the hospital and deducted from the amount paid to the hospital by the plan, it was explained.

The new arrangement was described in detail at the last monthly meeting of the Chicago Hospital Council at which time the council acted on a recommendation of its Blue Cross advisory committee and requested that Blue Cross adopt a payment schedule giving hospitals 100 per cent of charges or 110 per cent of costs.

Present hospital payments are fixed at a maximum of 8 per cent above average daily charges for a base period early in 1947 under a temporary agreement which expires March 1. At that time, the plan has announced, payment will be resumed at 97 per cent of hospital charges.

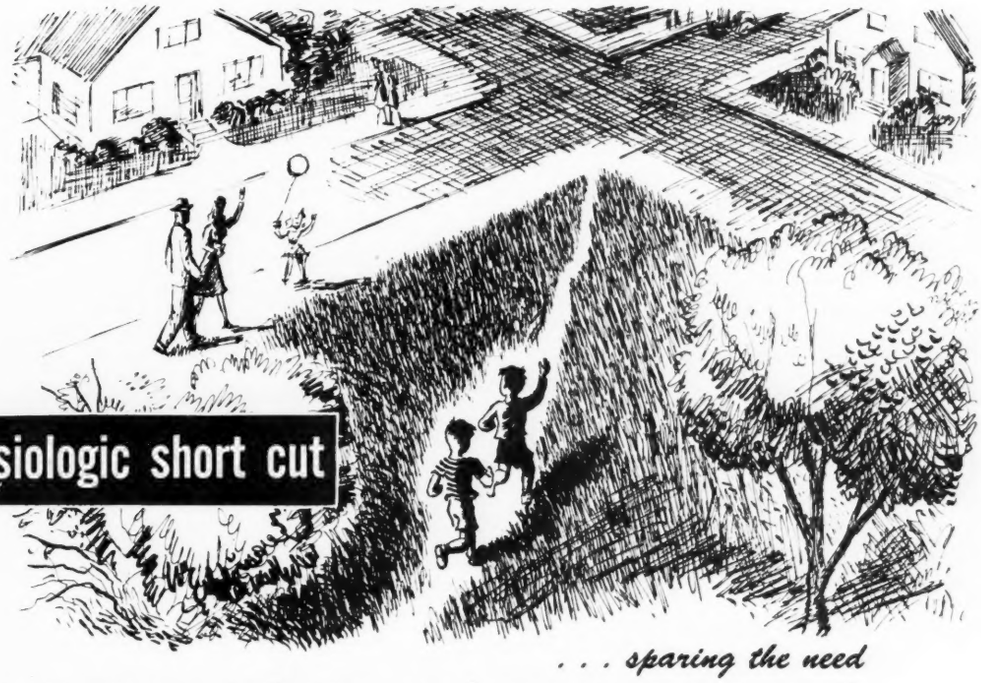
Under the proposed new arrangement, members who elect to keep the comprehensive service contract will pay $1.50 instead of $1.25 a month for single membership and $3.75 instead of $3.25 a month for family membership. Subscribers who elect instead to continue at the lower rate and make a daily payment in event of hospitalization are divided into two groups. Subscribers in pay roll deduction groups will pay $1.50 a day to the hospital for the basic period of hospitalization and subscribers on individual direct payment will pay $2.75 a day to the hospital, it was explained. The plan has not yet been approved.

The Illinois Central Hospital has withdrawn as a member hospital in the plan, it has been announced, and a statement has been issued to member groups indicating that only emergency cash benefits will be paid for Blue Cross patients hospitalized there.

## Plan Nurse Education on College Level

DENVER.—An agreement between the city of Denver and the University of Colorado will provide a nursing education program of college caliber to be carried on at both Denver General and Steele hospitals under University of Colorado administration, according to a recent university announcement. The new nursing education arrangement was put into effect January 1 and is known as the Denver General Hospital Division of the University of Colorado School of Nursing, the report said.

Under the new agreement, the Colorado Training School, oldest nursing school in the state, has become a unit of the University of Colorado School of Nursing. While a program leading to the bachelor of science degree in nursing is being developed at the Denver General Hospital Division, students can enroll and obtain the certificate of graduate nurse by studying for three and a half years.

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1. Editorial: J. A. M. A., 121:346, 1943.
2. Nadal, J. W.: Northwest Med., 46:444, 1947.
3. Sprinz, H.: Med. Clin. North America, 30:363, 1946.
4. Brunschwig, A., Clark, D. E., and Corbin, N.: Mil. Surgeon, 92:413, 1943

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# NEWS...

## Budget Estimates for New Fiscal Year re Health, Hospitals

WASHINGTON, D.C. — The President's budget estimates for the new fiscal year assume the creation of a National Science Foundation. Last year Mr. Truman vetoed the bill that would have established such an agency. In this year's message, the President expressed hope that the Congress would pass a bill for this purpose "in keeping with the principles of responsible and efficient administration."

The Office of Vocational Rehabilitation administers the grants to states for carrying out the rehabilitation program established by the Vocational Rehabilitation Act of 1943. Payments to states for 1949 are estimated at $21,475,000, an increase over estimated requirements for 1948 of $3,475,000.

Total appropriations estimated for 1949 state aid programs are more than double 1948 funds; however, the greater part of this increase is for grants for hospital construction.

There is a major decrease in the funds required in 1948 for nurses' training programs since enrollment in the cadet nurse corps was terminated in October 1945. Payment of stipends to cadet nurses will be completed in 1948. The 1949 estimates provide funds for completion of the auditing of nursing school accounts.

Work of the office of the surgeon general of the U.S. Public Health Service will continue in 1949 with relatively minor changes, said the President in his budget message. These changes will consist principally of increased activities in the division of sanitary engineering; development of the division of nursing, and small increases in the management staff commensurate with the expansion of programs.

Title V of the Social Security Act, as amended in 1946, authorizes annual appropriations for the Children's Bureau totaling some $22,000,000. This money is awarded in grants to states for maternal and child health services, services for crippled children, and child welfare services. Moderate increases were recommended for 1949.

The President also urged Congress to authorize the Federal Works Agency to make additional commitments for repayable advances to states and localities for planning community facilities.


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# NEWS...

## Diarrhea Epidemic Closes Hospital Maternity Department

PASADENA, CALIF.—An epidemic of infant diarrhea caused the death of four infants in Huntington Memorial Hospital nursery last month and was considered a possible contributing factor in the death of four prematurely born infants in the same hospital. Nineteen infants were stricken with diarrhea at the height of the epidemic which caused the nursery to be closed, it was reported. A statement issued January 8 by Alden B. Mills, administrator of the hospital, said:

"In a conference with local and state health department officials it was decided yesterday to close the maternity department of the Huntington Memorial Hospital pending study in the state virus laboratory of specimens from a series of infants in the hospital who have diarrhea.

"In addition, studies are being made in the hospital's laboratory and in the laboratory of the city health department. These studies will, it is hoped, determine whether this is the same virus now affecting the adult population so generally. Hospital officials deplored the fact this closing comes at a time when hospitals are so seriously overcrowded."

## Colorado General Opens TB Ward

DENVER.—A ward for the care of tuberculous patients was opened at Colorado General Hospital here February 1, Dr. Ward Darley, director of the University of Colorado Medical Center, announced today.

Accommodations for the tuberculous patients at Colorado General Hospital were made possible by altering a ward used for the care of polio patients for the last year and a half. About twenty-eight tuberculous patients can be accommodated in the new ward. Priority will be given those requiring surgery.

"In altering the ward, every effort has been made to follow modern concepts for the care and treatment of tuberculosis," Dr. Darley said. "Close attention has been paid to the matter of protecting personnel working on the ward and to the matter of carrying out modern technics to prevent the spread of the disease."

# NEWS . . .

## To Seek Efficient Medical System for Unified Armed Forces

WASHINGTON, D.C. — Secretary of Defense James Forrestal asked January 1 for an impartial study of the medical services of the armed forces with a view to obtaining the best possible medical system for the unified armed forces.

Topping the problems for which Secretary Forrestal specifically asked early attention was the possible consolidation or coordination of both the hospital and medical programs.

The Secretary of Defense addressed his memorandum to Dr. Paul R. Hawley, chairman of the committee on medical and hospital services of the armed forces. On the committee also are: Maj. Gen. Raymond W. Bliss, surgeon general of the army; R. Adm. C. A. Swanson, chief of the bureau of medicine and surgery of the navy, and Maj. Gen. Malcolm C. Grow, the air surgeon.

The committee's general mission is the making of a thorough, objective and impartial study of the medical services of the armed forces with a view to obtaining at the earliest possible date the maximum degree of coordination, efficiency and economy in the operation of these services.

Under the subject of improvement in the utilization of the existing hospital facilities of the several medical services, Mr. Forrestal asked for a consideration of the following points.

1. The number of hospital beds required in each geographical area to meet the collective needs of the three services.

2. The location of hospitals in regard to feasibility of their serving more than one of the departments.

3. What hospitals, if any, should be closed, placed in a standby status or disposed of as surplus.

4. Standards for hospitalization and the possibility of using other facilities, in lieu of regular hospitals, for minor convalescence and periodic medical examinations.

5. Utilization of hospital facilities in relation to the availability of qualified medical personnel, both general and specialized.

6. Whether utilization of available civilian hospital facilities might not be more efficient and economical for certain types of medical services required by the armed forces, generally or in specific areas.

Mr. Forrestal asked that study be given to the coordination of the current plans of the medical services of the armed forces for the construction of any new hospital facilities in the future, having in mind the type of considerations listed above and also the possibility of developing joint criteria for the design of hospitals.

The Secretary of Defense suggested that attention be given to the allocation to one service of the responsibility for providing all hospitalization and medical care for all services in certain fields of medicine, such as tropical medicine, neuropsychiatry, radiological injuries, prosthetics and serious disorders of the ear and eye.

Among other things, Mr. Forrestal wanted attention given to: the development of common standards, practices and procedures among the medical services with respect to the physical and mental requirements for entrance into the services and for disability dis-

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charges; preventive medicine; the organization, administration and operation of hospitals; improvement and standardization of medical records and nomenclature; cost accounting systems; forms; specifications for supplies and equipment; regulations.

Mr. Forrestal asked that consideration be given to the joint use of highly specialized personnel and to the possibility of interchange of medical personnel.

## Gregg Recommends Rejection of Plan to Merge Schools

RICHMOND, VA.—A proposal that the two medical schools in Virginia be merged under one board was recommended for rejection by Dr. Alan Gregg, director of the Rockefeller Foundation Division of Medical Sciences. Following investigation of the Virginia Medical School Hospital operation, Dr. Gregg reported that the proposed move would effect no operating economies and might lead to confusion that would outweigh any possible advantage of uniformity.

Instead, Dr. Gregg recommended that the state financial structure be altered to show a distinct separation of medical school and hospital operation, that certain board members be selected to serve both the Medical College of Virginia in Richmond and the University of Virginia at Charlottesville, and that a state board of medical care be established to supervise hospital administration for the two institutions.



## Study Value of Mass Radiography in Cancer Diagnosis

BALTIMORE.—Whether or not mass radiography will prove to be a valuable diagnostic weapon in stomach cancer will be tested in a study which began at the Johns Hopkins Hospital last month.

The method to be used is an adaptation of the technic now used for tuberculosis detection, the photofluorographic process in which a fluoroscopic image of the chest is recorded on small films, simply and inexpensively. The work is being conducted by the department of radiology of the hospital and the Johns Hopkins University School of Medicine, aided by a grant from the U.S. Public Health Service, the hospital reported.

Although it is hoped to examine 10,000 patients during the first year, it was emphasized that this is just a pilot study to evaluate the potential worth of applying the technics to extremely large population groups as a routine public health measure, as is now done in the tuberculosis detection program.

## Hospitals Use Television

CHICAGO.—The first use of television as a public education medium for hospitals was made with the showing of the American Hospital Association's film, "You're the Doctor," on Station WBKB in Chicago on New Year's Day. With the cooperation of the television station, "You're the Doctor" was broadcast to the 11,512 receiving sets in private homes and public places in the Chicago area at 7:45 p.m., January 1.

# NEWS . . .

## Begin Investigation of Death of Baby in Mayor's Office

MINNEAPOLIS.—An investigation to determine responsibility for the death of a four month old baby in the city hall office of Mayor Hubert Humphrey was ordered here January 21 when the child's parents charged that physicians at Minneapolis General Hospital refused to accept the baby as a patient the day before it died.

Mr. and Mrs. Arthur Jensen, the parents, said the baby was examined in the clinic at the hospital, then turned over to them to be taken home. They brought the baby to city hall on the morning of January 20 to make an appeal to the mayor for admission to the hospital. The baby died in the mayor's office while the parents were waiting in the city hall for an interview with a city official.

Dr. D. W. Pollard said that hospital physicians reported the baby was suffering from only a "slight respiratory ailment" when examined at the hospital. He explained that hospital facilities were overcrowded and it was impossible to hospitalize all patients with these symptoms.

A coroner's autopsy revealed that the baby died of laryngeal-tracheal bronchitis. This might readily have developed so rapidly, the coroner explained, that hospital physicians who examined the baby on the previous day would have found nothing more serious than a slight respiratory infection as reported.

## Expansion Program Announced

EAU CLAIRE, WIS.—Plans to expand the Luther Hospital which has been filled to capacity for so long that a "state of emergency" is said to exist were announced by the hospital board last month. The project as announced calls for the addition of 100 beds to the present 170 bed plant, Herman D. White, chairman of the hospital board, said. It will cost between $800,000 and $1,000,000 and will include a new pediatric department, communicable and psychiatric units, improved operating rooms and additional facilities for chronic, surgical and medical patients. N. E. Hanshus is administrator of the hospital.

# NEWS...

## Red Cross Starts First Unit of Network of Blood Centers

ROCHESTER, N.Y.—The first unit of a network of regional blood centers to be operated by the Red Cross in cooperation with physicians and hospitals was opened here January 12, Basil O'Connor, president of the American National Red Cross, reported. The Rochester center will serve twenty-seven hospitals in eleven surrounding counties and involves seventeen Red Cross chapters.

The new national blood program is designed to furnish whole blood and blood derivatives eventually to the entire nation. The overall program is long range in its aspects and is estimated to take from three to five years before all communities are reached. Medical authorities estimate that approximately 3,700,000 donations will be required annually to meet national medical needs.

Plans call for the eventual establishment of approximately 140 metropolitan centers throughout the country, with 250 secondary centers in smaller communities and several hundred mobile units to serve the rural and suburban areas.

Inauguration of the Rochester operation will be followed by the establishment of similar centers in Washington, D.C., Atlanta, Ga.; Louisville, Ky.; Omaha, Neb.; Stockton, Calif., and the integration into the national system of a center already operating in Wichita, Kan.

Dr. Ross T. McIntire, retired surgeon general of the navy, who had firsthand opportunity to observe the benefits the wounded derived from the wartime Red Cross blood program, is national director of the new Red Cross project.

The Red Cross undertook the new national blood program only after long consultation with leaders in the American Medical Association, the American Hospital Association, the United States Public Health Service, and with the army, the navy and the Veterans Administration. The entire cost of collecting, processing and distributing blood to hospitals will be borne by the Red Cross.

## Three Man Board Takes Responsibility for TB Sanitarium

CHICAGO.—Complete responsibility for operation of the Municipal Tuberculosis Sanitarium here, including the discharge or resignation of a number of department heads, was accepted by the three man board of trustees of the sanitarium in a public statement last month. The statement was issued in response to criticism of the board and its chief executive officer, Dr. Arthur W. Newitt, by members of the city council. The sanitarium board consists of Francis R. Lyons, president; Dr. Herman N. Bundesen, vice president, and Dr. Ernest E. Irons, secretary.

The statement was also signed by nine members of the sanitarium's medical advisory committee.

"The aldermen or any others who may feel we are not doing right, or who wish to protest about what we do, should quit running to the mayor with their troubles. They must come to us. If they have a genuine cause we'll listen; if not they needn't waste our time and theirs."

ST. JOHN'S HOSPITAL, TULSA, OKLAHOMA

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# NEWS...

## Maryland Medical Plan Approved by State Insurance Department

BALTIMORE. — Approval of a non-profit, voluntary, prepaid medical care plan for Maryland, to be known as Maryland Medical Service, Inc., and to be administered by Maryland's Blue Cross, has been given by the insurance department of Maryland, the Blue Cross office announced last month.

The new plan will be offered to the public about Oct. 1, 1948, according to J. D. Colman, executive director of Maryland Hospital Service, Inc., or soon after a significant majority of medical practitioners doing hospital practice agree to become participating physicians.

Maryland Medical Service will be a separate organization from Maryland Hospital Service with its own board of directors, it was explained, but Blue Cross will handle administrative details, including enrollment of subscribers, collection of membership fees, and payment of participating physicians. Surgical, medical and maternity services in hospitals are provided. Home and office visits are not covered except for treatment of obstetrics, fractures or dislocations, and for surgical after-care.

The new plan has the approval of the state medical society and the medical societies in all the counties. Payments to physicians under a fee schedule will be made as follows for hospitalized patients:

If a subscriber is a patient in a semi-private room, the physician will accept the rates of Maryland Medical Service as full payment. If the subscriber is a patient in a private room, the physician will accept Maryland Medical Service payment as credit against his usual bill.



## B.S. Degree in Nursing to Be Given Students at Johns Hopkins

BALTIMORE.—The bachelor of science in nursing degree will be conferred by Johns Hopkins University on qualified students of the school of nursing of Johns Hopkins Hospital in a new educational program announced recently for the university and hospital by Dr. Isaiah Bowman, university president, and Dr. Edwin L. Crosby, director of the hospital.

Under the cooperative plan, the university will award the degree to candidates who complete at least two years of approved college work in an accredited institution of higher learning and then pass successfully a program of study at the hospital school of nursing.

Dr. Bowman, who has been chairman of the advisory board of the school of nursing for many years, pointed out that the university and hospital have long had a joint interest in nursing education. Since 1934, the university has granted credits toward a degree to graduate nurses.

## Plan to Replace Hospital

OMAHA, NEB.—A new fifty-five bed hospital is planned for Norfolk, Neb., to be operated by the Missionary Benedictine Sisters there. The new hospital will replace the present Our Lady of Lourdes Hospital in that city, it is reported.

# NEWS...

## Margarine Battle Starts in Senate

WASHINGTON, D.C. — Removal of special taxes and manufacturers' license fees on oleomargarine is sought by manufacturers' lobbies here, while farmer and dairy product groups are fighting to maintain the restrictive laws, newspaper correspondents have reported.

As hospital representatives and others in New York State move closer to getting restrictive regulations lifted, the "lobby battle" in Congress is being joined, observers explained.

Sen. J. William Fulbright, Arkansas Democrat, is principal sponsor of a Senate bill to lift the federal restrictions.

"Discriminatory margarine laws have no place in the United States," Senator Fulbright has declared. "They are directly opposed to the spirit of free enterprise. They constitute the only case where federal tax is levied on one domestic product for the benefit of another competing product. There is no sound reason for them. They are inflationary. Because of them the consumers have to pay for margarine and waste time and food in preparing it for use."

Senators and congressmen supporting Senator Fulbright's position believe they will be successful in removing the margarine restrictions, it was reported

## Experimental Biology, Medicine Institute

WASHINGTON, D.C.—An experimental biology and medicine institute has been established in the National Institute of Health, U.S.P.H.S. The new research institute will combine the functions of the division of physiology and the pathology and chemistry laboratories.

Surgeon General Thomas Parran said that the formation of the new institute is part of a wider organization of the National Institute of Health. Four other divisions and laboratories engaged in scientific research also will be consolidated into two additional institutes. All will be modeled after the National Cancer Institute.

The director of the newly established institute is Dr. William Henry Sebrell Jr. He will also serve as associate director of the National Institute of Health.

# NEWS...

## To Improve Advanced Training of Medical Officers in Army

WASHINGTON, D.C.—A number of changes in the army medical department's graduate professional education program has been announced by Surgeon General Raymond W. Bliss. Innovations, effective immediately, are designed to maintain the quality of patient care and to elevate the caliber of training at army general hospitals.

Graduate training in psychiatry is being strengthened and concentrated in three general hospitals; many qualified civilian consultants will be added to the attending staffs of the hospitals engaged in teaching; the administrative responsibilities of qualified teachers will be lessened by the transfer of routine paper work to administrative assistants; qualified instructor personnel will be kept on duty in its present assignments for as long as possible, and special instruction in the best methods of medical education is being provided for key military instructor personnel.

Better means of resident-intern selection and evaluation of progress are being placed in operation, Gen. Bliss stressed. The actual content of the program of instruction for each special field will be developed in more detail. Portions of the program will be delegated to the military or civilian instructor who is best qualified in each particular phase so that accurate and complete coverage will be obtained within the residency span.

At present 204 regular army medical corps officers are participating in the postgraduate instruction program as residents in the various recognized special fields of medicine and surgery. The objective of each is certification as a diplomate by one of the 16 American specialty boards in the field of medicine and surgery.

In addition, 50 positions were made available January 1 to applicants for the regular army who are in the continental United States and 50 more will be offered to applicants who are overseas, effective July 1.

## F.W.A. Sells Lanham Act Hospitals

WASHINGTON, D.C.—The Federal Works Agency has sold 108 hospitals and nurses' homes constructed and equipped under the Lanham Act, Maj. Gen. Philip B. Fleming, the administrator, declares.

These hospitals built in war-congested areas have been disposed of for the most part to local public agencies. Specifically, 81 hospitals and nurses' homes were purchased by local governmental agencies, the remaining by nonprofit groups.

Some 441 projects, including schools, water and sewer works as well as hospitals, are still immediately available for sale. The total original cost to the federal government of these projects was $68,086,524. The original cost of the hospitals and nurses' homes already sold as of Nov. 30, 1947, was $18,439,615. The government has realized in their sale $5,636,648. Thirty-seven states and territories have added to their hospital facilities through these purchases.

More than $14,000,000 worth of hospitals and nurses' homes are still available for disposal.

# NEWS...

## Seek to Improve Education of Crippled Children

NEW YORK.—Improvement of educational opportunities for children with orthopedic defects who receive their schooling in hospitals and convalescent centers will be the aim of a special conference of educators February 26 and 27 at Atlantic City, N.J. The conference is sponsored by the National Foundation for Infantile Paralysis as part of its service to polio patients. Inasmuch as many children receive all or much of their schooling in such institutions, the therapeutic benefits of education are a significant phase of their total treatment, the foundation points out.

Teachers in the 257 treatment centers of the country that have academic facilities, physicians, school administrators, hospital administrators, staffs of teacher training centers, student teachers, nurses, physical and occupational therapists, medical social workers, and education program leaders of civic and women's clubs have been invited to attend the conference.

A survey of eighteen institutions recently made by Dr. Alice V. Keliher, professor of education, New York University, and Amy Hostler, dean of the Mills School, New York City, revealed where important improvements in educational facilities and methods can be made. Outstanding lacks noted were:

1. Absence of the case conference, built around the child himself, a procedure needed for successful education of the handicapped child.

2. Lack of appreciation of the teachers' important rôle in these institutions, resulting in their isolation from hospital staffs and educational groups in the community and in turn retarding the progress of patient-pupils.

3. Little attempt to rearrange conventional school hours and schedules to suit the needs of patients.

4. Almost complete lack of preschool programs for children of 2 to 6 years, in which age group many polio patients fall.

5. Lack of proper materials for group work, such as visual aids, space for assembly of bed and wheelchair patients for group discussion.



## For Medical Atomic Research

WASHINGTON, D.C. — Expenditure of $615,000 for building and equipping a six story medical and biological training and research center on the campus of the University of Rochester, Rochester, N.Y., has been approved by the U.S. Atomic Energy Commission, according to a recent announcement. The new medical center will provide facilities for training medical scientists and technicians to meet problems encountered in the field of atomic energy.

## Dr. Martha Eliot Honored

WASHINGTON, D.C.—Dr. Martha Eliot, associate chief of the Children's Bureau, was given an award for outstanding service to children by George J. Hecht, publisher of *Parent's Magazine,* January 15. The award has previously been presented to Katherine Lenroot, chief of the Children's Bureau, Walt Disney and Dr. Thomas Parran, surgeon general, U.S.P.H.S.

# NEWS...

## Red Cross Launches Nurse Enrollment Plan

WASHINGTON, D.C.—The Red Cross nurse enrollment plan for community service through Red Cross chapters was launched at national headquarters here recently when a group of professional nurses received the first Red Cross nursing badges issued under a new plan, a Red Cross release stated last month.

The group comprised the first nurses recruited to serve in the new American Red Cross National Blood Program which eventually will be in a position to supply, without charge for the product, all blood and blood derivatives needed by the nation. These nurses will take up their posts at Rochester, N.Y., and Atlanta, Ga. They were enrolled on behalf of those two chapters at national headquarters where they completed three weeks of training under supervision of Evelyn T. Stotz, nursing director of the blood program. Their primary responsibilities will be the care and protection of donors, under supervision of the medical director of the blood centers.

## COMING MEETINGS

AMERICAN DIETETIC ASSOCIATION, Hotel Statler, Boston, Oct. 18-22.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Traymore Hotel, Atlantic City, Sept. 19, 20.

AMERICAN HOSPITAL ASSOCIATION, Traymore Hotel, Atlantic City, Sept. 20-24.

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 19-22.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Roanoke Hotel, Roanoke, Va., April 15, 16.

CATHOLIC HOSPITAL ASSOCIATION, Cleveland Public Auditorium, Cleveland, June 7-10.

NEW ENGLAND HOSPITAL ASSEMBLY, Silver Jubilee, Hotel Statler, Boston, March 15-17.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Bellevue-Stratford Hotel, Philadelphia, April 28-30.

IOWA HOSPITAL ASSOCIATION, Hotel Fort Des Moines, Des Moines, April 24.

MARYLAND-DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION, Statler Hotel, Washington, D. C., Nov. 8, 9.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Wade Park Manor, Cleveland, May 3-5.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Hotel Gibson, Cincinnati, Feb. 18, 19.

NATIONAL EXECUTIVE HOUSEKEEPERS' ASSOCIATION, Brown-Palace Hotel, Denver, June 23-26.

NEW JERSEY HOSPITAL ASSOCIATION, Hotel Dennis, Atlantic City, N. J., May 20-22.

OHIO HOSPITAL ASSOCIATION, Deshler-Wallick Hotel, Columbus, April 6-8.

SOUTHEASTERN HOSPITAL ASSOCIATION, Biloxi, Miss., April 22-24.

TEXAS HOSPITAL ASSOCIATION, Dallas, March 4-6.

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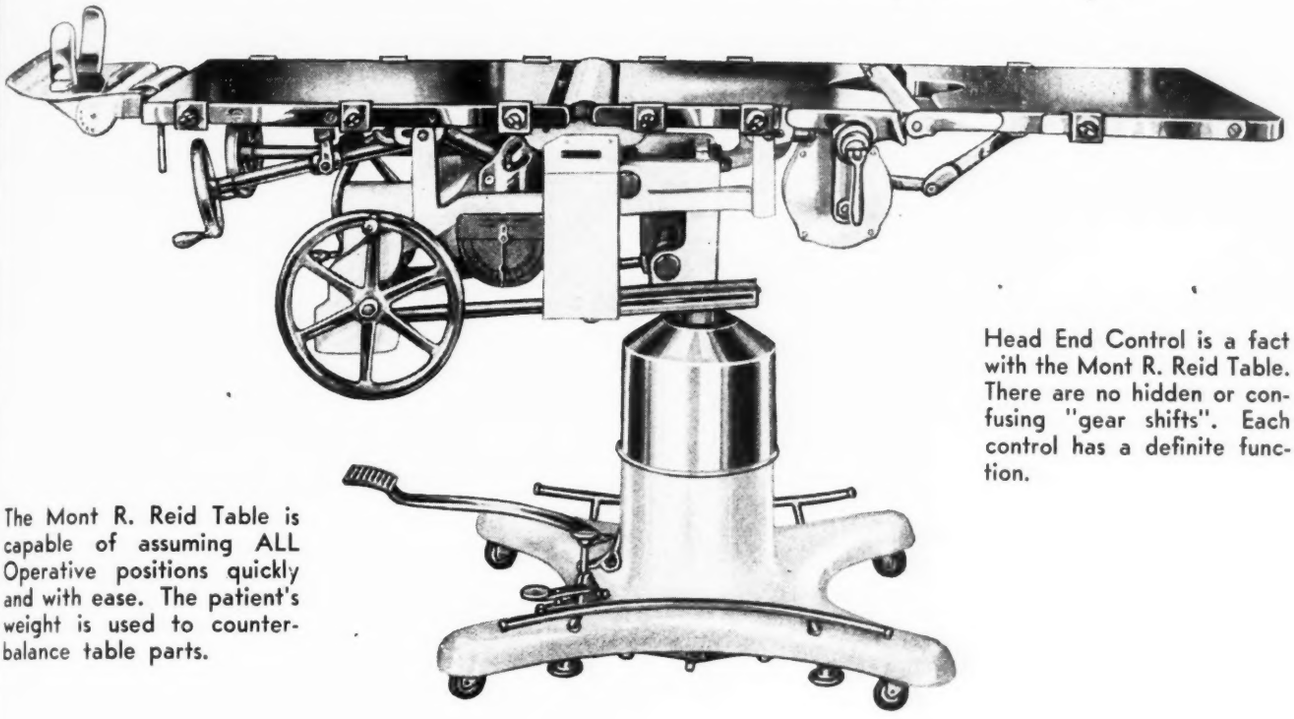

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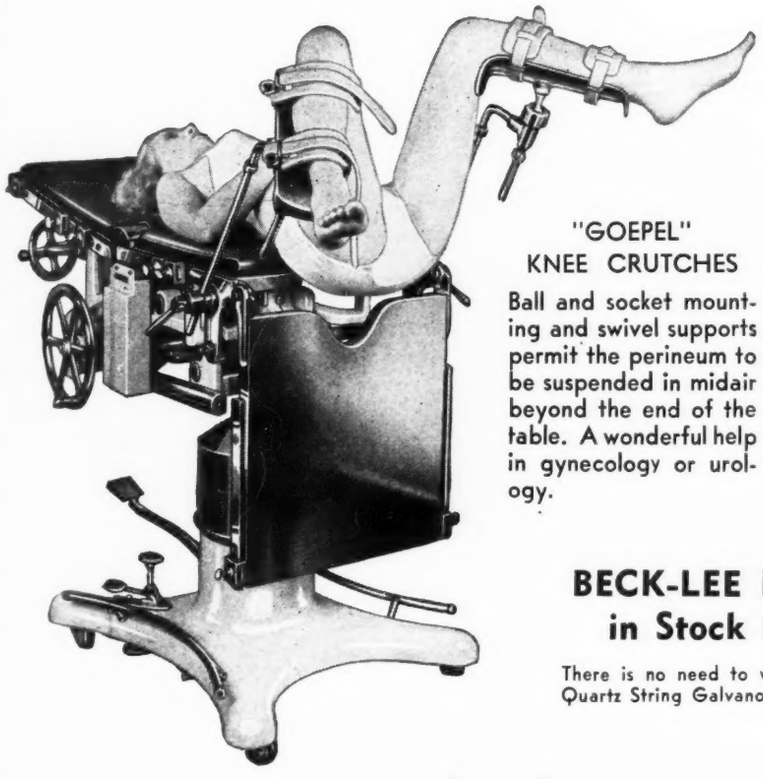

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Ball and socket mounting and swivel supports permit the perineum to be suspended in midair beyond the end of the table. A wonderful help in gynecology or urology.

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# NEWS...

## New Record Low for Crude Death Rate

WASHINGTON, D.C.—The year 1946 marked a new record low for the crude death rate in the United States, according to figures recently released by the National Office of Vital Statistics.

The death rate was 10.0 per thousand population as compared with 10.6 for 1945 and 10.4 in 1942, which held the lowest record to that date. The estimated death rate for the United States for 1947, based on data for the first ten months of the year, was 10.1.

During 1946 deaths from diseases of the heart increased for the third consecutive year. Cancer and other malignant tumors continued to increase. The number of deaths from other major chronic diseases decreased.

In 1946, as in 1945, new record lows were set for deaths from the major infectious diseases: pneumonia, influenza and tuberculosis. Maternal mortality also declined to a new low. Accidents accounted for close to 100,000 deaths.

The five leading causes of death in the U.S. in 1946 in rank order were diseases of the heart, cancer, intracranial lesions of vascular origin, nephritis and accidents other than motor accidents. This is the first year in which pneumonia and influenza combined was not represented among the five leading causes of death.

Number of deaths and death rates for the five leading causes of death in the United States in 1946 are shown in the table below. (These are exclusive of stillbirths and of deaths among armed forces overseas.)

**1946 Death Rate per Hundred Thousand Excluding Armed Forces Overseas**

| *Causes of Death* | *Number* | *Rate* |
|---|---|---|
| Diseases of heart | 429,230 | 306.8 |
| Cancer, malignant tumors | 182,005 | 130.1 |
| Intracranial lesions of vascular origin | 125,646 | 89.8 |
| Nephritis | 81,701 | 58.4 |
| Accidents, excluding motor vehicle | 64,622 | 46.2 |

## Get Training Grants for Mental Health Personnel

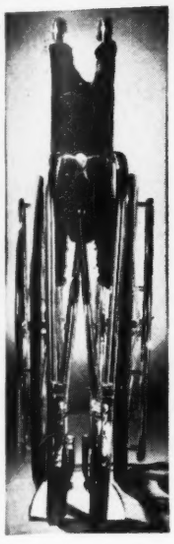
WASHINGTON, D.C.—Federal grants for training mental health personnel under the National Mental Health Act go to the University of Pennsylvania, the Menninger Foundation, Boston Psychopathic Hospital, University of Cincinnati, Institute of Psychoanalysis (Chicago), University of Kentucky, Tulane University and Washington University.

Training stipends to graduate students in psychiatry, clinical psychology and psychiatric social work will be administered by all the foregoing institutions except the Menninger Foundation, University of Kentucky and Tulane University.

## To Enlarge TB Hospital

WASHINGTON, D.C.—The Veterans Administration has accepted bids for the construction of a 150 bed addition to its tuberculosis hospital in Portland, Ore. The building, about 1,554,000 cubic feet in size, will have concrete foundations, brick-faced exterior walls with stone trim, hollow tile backing, reinforced concrete floors and built-up roof.

# For the Thrill of Happier Living



## a Parkside Folding Wheel Chair

*With the Parkside, many invalided persons can enjoy the pleasures of normal living. At work and recreation, the Parkside always provides safe, comfortable, versatile transportation.*

*In addition to the Parkside folding wheel chair, Gendron also manufactures more than 50 wheel chair models, and wheel stretchers, examination tables, invalids' commodes, backrests.*

The Parkside folding wheel chair encourages independence on the part of invalids . . . and patients. In the hospital, as well as in the home, patients quickly adapt themselves to the Parkside, and in a short time are perfectly capable of getting into the chair, propelling themselves about the hospital and then returning to their beds entirely without assistance from nurses or attendants. No detail of construction has been overlooked to provide patients with safe, comfortable, easy handling transportation. The Parkside glides smoothly and maneuvers effortlessly on ball bearing, rubber tired wheels. A rigid, two piece folding seat and flexible back provide luxurious comfort. Frame and folding mechanism are of stainless steel, triple plated and finished in gleaming chrome.

The Parkside folds easily, and is small enough to be carried in an ambulance or passenger car where it is ready instantly for transporting patients to and from the hospital. Or, the Parkside may be folded and placed conveniently against a wall so that hospital corridors and admitting rooms are kept uncluttered and open to passing traffic.

## Gendron Wheel Company

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# NEWS . . .

## Changing Age Pattern Requires Revise in Approach to Planning

NEW YORK.—A revised approach to hospital planning is made necessary by the changing age patterns in our society, a recent bulletin of the Hospital Council of Greater New York stated.

Pointing out that these changes are results of the trend toward increasing life span and decreasing birth rate, the council explained that the departure from what was sometimes accepted as a fixed balance among age groups in the population will alter the needs of all age groups for general care hospital facilities.

The greatest need in general hospitals at the present time is for "beds to serve persons in the second half of life," it was emphasized. Attributing success in extending the life span largely to advances in curative and preventive medicine, the council said, "Almost twice as many persons born in 1940 will reach their 80th birthday as those born in 1900."

The council also emphasized the need for studying the influence of age distribution, as well as the rate of growth and the size of the population, in determining the requirements for general care hospital beds after 1950.

In pointing out that the changing hospital bed requirements of various age groups in the total population can be met most effectively through coordinated planning, the council added, "The most satisfactory distribution of hospitals in a community will be the one in which each hospital is planned in accordance with the overall needs of the community and with regard for the announced plans of other hospitals in that area."



## "Nurse Shortage Critical"

CHICAGO.—Chicago's nursing shortage was described as critical, with 800 hospital beds idle for lack of nurses, by Dr. Andrew C. Ivy, vice president of the University of Illinois and director of its professional schools. The addition of new hospital facilities will be useless unless additional nurses can be recruited, Dr. Ivy said.

A recent survey showed that between five and ten thousand additional beds are needed in the Chicago area, he said, yet in some cases whole floors of hospitals today are closed. Dr. Ivy urged better housing for nurses as an inducement for recruiting. Lack of housing has compelled the Illinois Research Hospital to use eighty hospital beds as living quarters for nurses and interns, he said.

## N.U. Club Names Officers

CHICAGO.—Kenneth L. Winters has been elected president of the Hospital Club of Northwestern University, the club bulletin announced. Members of the club are students in the hospital administration program at the university.

Mr. Winters succeeds Jack Hahn who has been president during the last year.

Other officers are: vice president, Herbert R. Rodde; secretary-treasurer, Lea G. Beaudro; corresponding secretary, John W. Shy; historian, Norman L. Thompson; committee, Col. James B. Stapleton, Harry C. Back, Bergliot Larson.

# NEWS . . .

## Personnel Institute Planned to Improve Employe Relations

CHICAGO.—First of the American Hospital Association's 1948 series of institutes on hospital personnel relations will be held at Atlanta, Ga., February 23, 24, 25, according to an announcement from association headquarters.

Planned to give assistance and stimulate conscious planning for improved employe relations, the institute is not designed to train personnel officers. Rather, administrators, assistant administrators, and personnel officers will be helped to develop and maintain efficient work forces which will result in better patient care and more effective and economical operations, the association stated.

Particularly conscious of aspects of personnel relations affecting hospitals in the southeastern area, the local advisory committee determined such questions as these to be the subject of institute discussion: ways that payroll costs —approximately 60 to 75 per cent of operational cost in hospitals—may be related to employe output; technics (not requiring costly personnel departments) for improving morale, reducing turnover and absenteeism, increasing efficiency, and utilizing employe skills; and job analysis and evaluation as tools in establishing equitable salary and wage programs and avoiding unsound pay scales.

## British Doctors Still Opposed to Health Service

NEW YORK.—A report from London to the New York *Times* said that the British Medical Association's opposition to the national health service continues undiminished, with the association recommending that the plan be rejected by doctors.

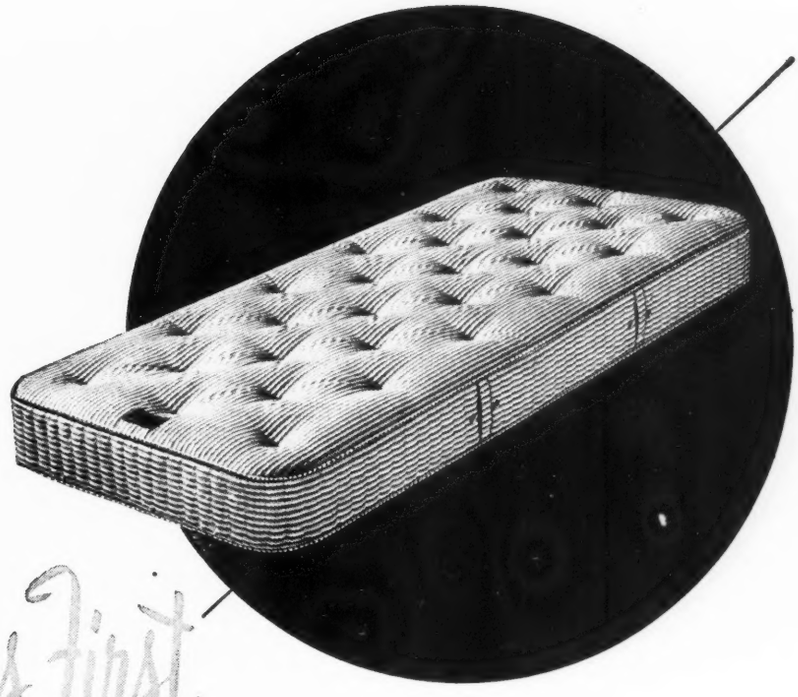
A recent association resolution declared that the national health service "in its present form is so grossly at variance with the essential principles of our profession that it should be rejected absolutely by all practitioners," the report said.

The British Medical Association is planning a poll in which 56,000 physicians will be asked to express their views on the government program. Government officials, through the Ministry of Health, have announced that the health service program will begin on schedule next July notwithstanding association objections. They predict that enough doctors will join the plan to assure efficient service.

## Special Gifts Total $270,000

ST. JOSEPH, MICH.—A total of $270,000 has been raised in the special gifts campaign to supplement the building fund for a new 100 bed Memorial Hospital here. The balance toward a $300,000 objective is expected to come in as the result of groundwork laid during the campaign, it was reported.

The campaign was a necessary sequel, owing to increased building costs, to one held three years ago in which $575,000 was raised in an appeal for a half million dollars. The total raised to date thus stands at $845,000. Both campaigns were under the direction of Kerchum, Inc., of Pittsburgh.



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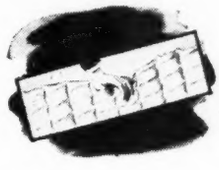
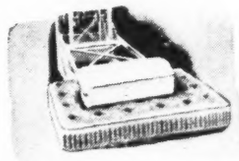
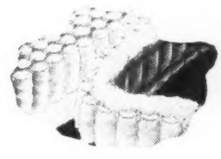


*Beautyrest "floating-action." Each coil works separately, like the keys of a piano. No matter what the patient weighs, he is supported—gently and evenly—in any resting position.*



*Exhaustive tests by the United States Testing Company (Hoboken, N. J.) proved that the Beautyrest mattress lasted 3 times longer than any of the other mattresses tested.*



*Sag-Proof Edge. The outer row of Beautyrest coils is fastened to the prebuilt border by an exclusive process . . . the edges never sag or break down. Assures "mid-mattress" comfort right up to the edge.*

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# NEWS...

## Health, Welfare, Hospital Construction in Budget Message

WASHINGTON, D.C.—In his budget message to Congress January 12, the President recommended the spending of $116,000,000 in the fiscal year ending June 30, 1949, mainly for revisions of public assistance and initial administrative costs of a medical care program. He recommended broader coverage under old-age and survivors' insurance to be financed through pay roll taxes.

In addition, the President called for contract authorizations of $119,000,000 for public health programs. This total includes $75,000,000 for the federal aid hospital construction program, $26,000,000 for research and hospital facilities for the Public Health Service, and $18,000,000 for the District of Columbia hospital center.

Included in the recommendations for 1949 is an appropriation of $60,000,000 to liquidate the prior year's contract authorization for federally aided hospital construction.

The Veterans Administration hospital construction program for the new fiscal year provides no authorization for additional new beds. It does include a recommended additional contract authorization of $15,000,000 to meet the increased construction costs of new hospitals previously authorized and $28,000,000 for the repair, alteration and renovation of existing hospitals and homes. The $230,000,000 estimate of appropriated funds is for liquidation of obligations against contractual authority previously provided for repairs, alterations and renovations of existing facilities and for approximately 91 new hospitals with 46,900 beds estimated to be completed or under construction by June 30, 1949.

St. Elizabeths Hospital here gets a recommended increased appropriation over last fiscal year of approximately $3,000,000. The increase results from the hospital's plan to complete construction of the storeroom and of a treatment building, planning for additional construction, and major items of repair and preservation of buildings and grounds.

## Urge Hospital for Alcoholics

ALBANY, N.Y.—Establishment of a state hospital exclusively for alcoholics was recommended by a joint committee on alcoholism including judges, clergymen, psychiatrists, penologists and representatives of the community. The recommended institution would have fifty beds and would be equipped with modern facilities and administered to take advantage of new technics as they are discovered. The committee recommended that the pilot institution be established in or near a heavily populated area where there is likely to be a large percentage of problem drinkers.

The committee also recommended that state mental hygiene laws be amended to provide for commitments to public mental institutions for long term care.

## Plan Enrolls 100,000

OMAHA, NEB.—Nebraska Blue Cross reached an enrollment of 100,000 members last month, J. H. Pfeiffer, executive director, announced at a conference of Blue Cross and Medical Service Plans workers here. Employes of the plan were given Blue Cross emblems.

# NEWS...

## Suggest New York Appropriate Funds for Dental, Medical Schools

ALBANY, N.Y.—More state facilities for dental, medical and nursing students were recommended here last month by the research staff of the governor's state university commission. A "serious gap" exists between available facilities and the number of persons needed in these professions the commission reported. To meet this need, it was suggested that the state appropriate funds to establish new dental and medical schools.

Specifically, establishment of three dental schools and expansion of the existing school at the University of Buffalo were recommended. Also facilities for 60 more medical students a year in state-supported schools should be established, the commission said. Especially, it was recommended the proposed state schools should seek to train physicians for public health and administrative as well as clinical responsibilities. Such a school, it was emphasized, could select students without regard to race, creed, color, sex and "minimize the economic deterrents that bar low income individuals from undertaking the study of medicine." The state needs 10,000 additional nurses now and should have still another 10,000 or more by 1960, the commission reported. Yet, present schools cannot be expanded sufficiently to meet these demands. The commission recommends establishment of four university schools of nursing in existing medical centers. The proposed state schools would offer two years of general education in a combined program with three years of professional nursing education.



## Public Relations Stressed at Mid-Year Session of State Officers

CHICAGO.—Public relations as it affects all areas of hospital association activity was the theme for the mid-year conference of presidents and secretaries scheduled here for February 6 and 7. The conference program was aimed at showing how state associations can help hospitals present the facts about all phases of their operations to the public in their individual communities.

Specifically, the program stressed steps that need to be taken to acquaint the public with the economics of hospital care and particularly with the factors underlying sharply increased hospital costs. Another subject of interest to association officers in their work with hospitals, as covered by the conference, was the hospital-nursing relationship.

Convention planning, institutes of hospital personnel, federal and state legislation and other subjects were also discussed by the state association officers attending the conference.

## To Build $200,000 Addition

OMAHA, NEB.—A $200,000 addition is being planned for St. Catherine's Hospital here. The addition will include new kitchens, dining rooms and laundry. Later steps in the expansion program call for additions to the obstetric and pediatric departments of the hospital.

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# NEWS...

## University of Iowa Officials Criticize State Hospital Plan

DES MOINES, IOWA.—Charges that the state hospital plan for Iowa failed to give proper consideration to statewide medical and hospital services being rendered by University of Iowa Hospitals were made by Dr. Virgil M. Hancher, university president, and Gerhard Hartman, superintendent of University Hospitals, at public hearings.

Earlier the university officials had expressed the same criticism of the hospital plan at meetings of the state's hospital advisory council of which Mr. Hartman is a member. The advisory council and health department officials who drafted the plan failed to make a proper evaluation of the distribution of hospital and medical services offered by the university throughout the state, President Hancher and Superintendent Hartman declared.

"With its ambulance system the University Hospitals reach out and render care with a comprehensive hospital and medical service for every county," Dr. Hancher stated in a letter to Dr. Walter L. Bierring, state health commissioner.

Amplifying this criticism of the plan, Mr. Hartman asserted that small hospitals such as those favored in the Iowa plan often cause social waste because of unoccupied beds in normal times. Furthermore, he said care provided in such small hospitals is poorer than that offered in larger units.

Robert C. Hanlon, head of the state health department's hospital division, said the plan would be forwarded for U.S. Public Health Service approval as drawn, but that some recognition of the statewide hospital service rendered by the university would be added before final approval was sought.

During the public hearings, Alfred Bieber, a member of the executive committee of Lutheran Hospital, Sioux City, condemned the entire federal plan as being predicated on "the idea that there will be state medicine or socialized medicine in the next five or ten years."



## Michigan Agencies Requested to Use Government Formula

LANSING, MICH.—Trustees of the Michigan Hospital Association passed a resolution requesting state agencies contracting for hospital service to use the standard government reimbursable cost formula now used by federal agencies. The resolution has been sent to all agencies within the state not now using the formula, the Michigan Hospital Association *Bulletin* has reported.

The *Bulletin* also reported formation of the Michigan Hospital Advisory Council to aid in administration of Public Law 725 within the state. Members of the council are Ronald Yaw, Grand Rapids, president-elect of the association; Stanley R. Banyon, Benton Harbor, hospital trustee; Sister Marie Bernard, Sisters of Mercy, Detroit; Dr. John P. Wood, Birmingham, past president, Michigan Osteopathic Association; Dr. Ralph Lindberg, Detroit Osteopathic Hospital; Victor Lepisto, Wakefield banker; Dr. John R. Rogers, past president, Northern Michigan Health Society, and Dr. A. D. Allen, Bay City surgeon.

# NEWS...

## Illinois Group Considers Appointing Executive Secretary

CHICAGO.—Everett Jones, vice president of The Modern Hospital Publishing Company, and George Bugbee, executive director of the American Hospital Association, were among the speakers who addressed the annual mid-year conference of the Illinois Hospital Association at Springfield, January 29. Mr. Jones urged hospitals to consider the addition of practical nurses as a means of meeting the nurse shortage economically and helping to reduce operating costs, and Mr. Bugbee discussed financial legislation affecting hospitals.

The association considered at length a proposal recommending the appointment of a full time executive secretary to coordinate the efforts of all hospitals in the state in dealing with problems of mutual interest and concern.

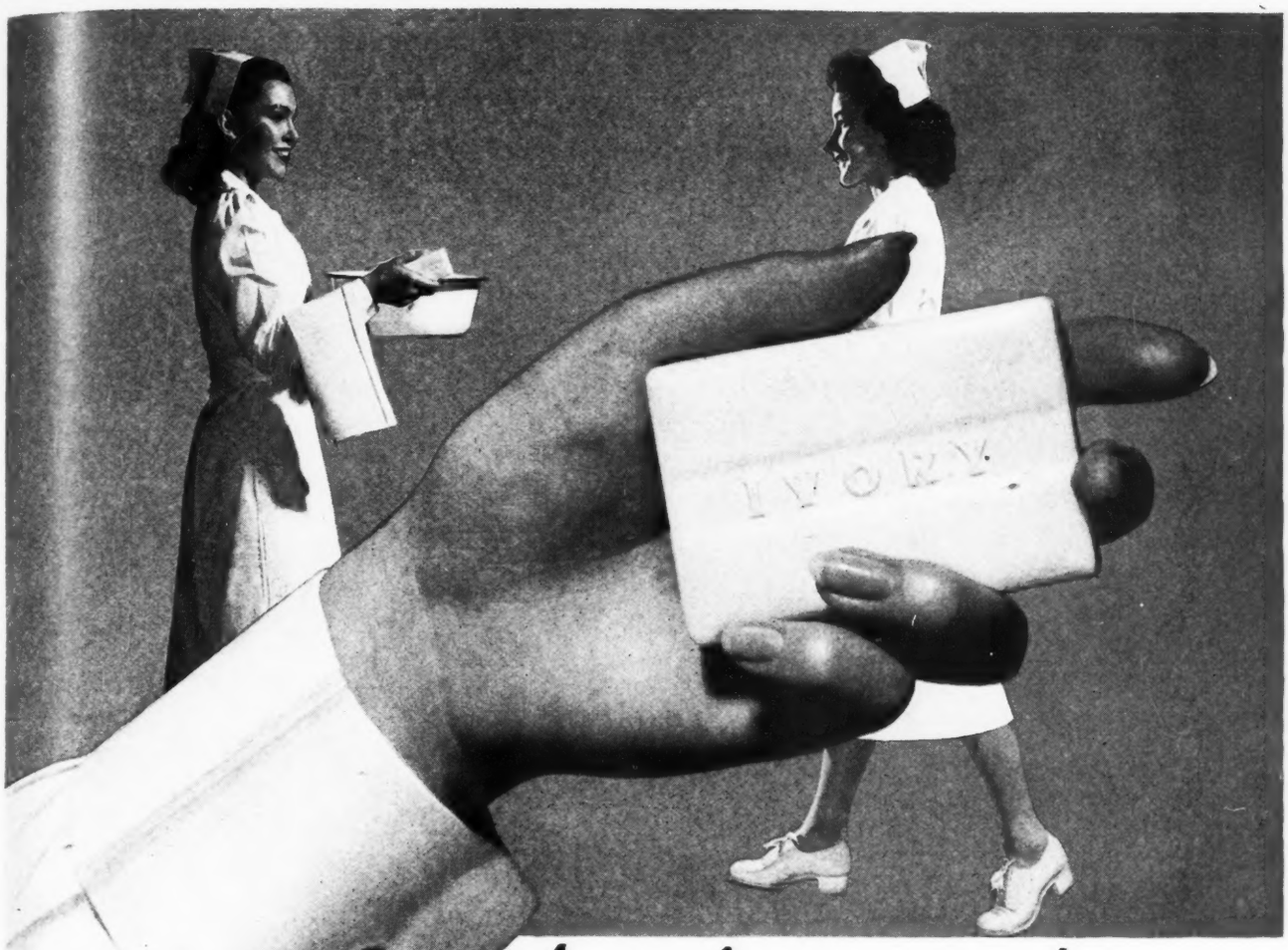
The state Blue Cross commission discussed a proposal that the state hospital group be represented on the board of Plan for Hospital Care, Chicago, which now includes a large number of downstate hospitals. It was pointed out that hospitals have some representation in the plan through the Chicago Hospital Council's plan advisory committee, but that the downstate group is not represented in any way.

## Institute for Anesthetists

CHICAGO.—An institute for nurse anesthetists will be held at Oakland. Calif., March 8 to 12, American Hospital Association headquarters announced last month. Sponsoring organizations for the institute include the American and California associations of nurse anesthetists and the Association of Western Hospitals. "Many nurse anesthetists have been looking forward to this announcement, and we hope that you will bring this to the attention of the nurse anesthetists who work in your hospital," the associations stated in a communication to administrators.

## Plan Sixty Bed Addition

CHICAGO.—A sixty bed addition costing $400,000 is under construction at Mount Sinai Hospital here, Dr. Stephen Manheimer, hospital director, has reported. The addition will be ready for occupancy this spring, Dr. Manheimer said.

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It is no mean task to improve a product as fine as Ivory. Yet Ivory actually has been improved four ways. New Improved Ivory takes one-third less time to lather up, even in hard water . . . produces more lather with no more effort . . . a longer-lasting lather.

Finally, new improved Ivory is handsomer than ever and easier to handle. The new design lets excess water drain off the bar more readily, keeping it dry when not in use.

New improved Ivory is ready — and exceptionally well qualified — to serve the cleansing needs of your institution. This distinctively finer Ivory is available in sizes from ½ ounce to 3 ounces, either wrapped or unwrapped.


*Procter & Gamble*

**MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER**

# NEWS...

## A.M.A. Editorial Blasts Rebates, Commissions

*(Continued From Page 120.)*

Medical Association has fought this menace to the quality of medical service and to the good repute of medical practice. Resolutions have been passed by the official bodies of the association unequivocally condemning such practices. The judicial council has repeatedly urged the expulsion or other action against physicians proved to have participated in such procedures. The leaders of surgery, ophthalmology, orthopedic surgery and pharmacy have been unanimous in pointing out the extent to which such commercial considerations may break down the good repute of the specialties concerned. The American College of Surgeons adopted an oath to be taken by its fellows to the effect that they would not participate in the secret division of fees. The Principles of Ethics of the American Medical Association have declared the unethical character of such divisions—direct or indirect.

"Now the development of greater complexity in medical practice and in medical relationships has introduced new factors into this problem of barter and trade. The development of roentgenology as an important medical specialty and the establishment of clinical pathologic laboratories to which physicians send patients for the making of highly technical and often costly tests have introduced new sources of rebates, kickbacks and commissions. In some communities means have been proposed for evading the condemnation of medical organizations and societies through the establishment of corporations, cooperative laboratories, and roentgenologic offices of multiple ownership.

"As might have been anticipated, the ultimate development was recognition by governmental agencies of the fact that the unprotected public was being exploited by such methods. The first warning, and one of tremendous significance, was the indictment by the Department of Justice of two manufacturing optical agencies and of a considerable number of ophthalmologists who participated in a plan which took hundreds of thousands of dollars from unknowing patients. A full report appeared in the *Journal of the American Medical Association* when the Department of Justice took this action during 1946. A popular periodical with millions of circulation has called on the medical profession to cleanse itself as it has repeatedly cleaned its own house in the past. The house of delegates asked the secretary of the American Medical Association to call the situation to the attention of every state and county medical society in the nation and to urge on these societies the initiation of the necessary steps toward ridding medical practice of these parasites. The better business bureaus in several large communities, notably Los Angeles, have begun a campaign of enlightenment of the public regarding the extent to which these abuses prevail in their communities; they, too, have called on the medical profession to take steps to stop this pernicious practice.

"The housecleaning has been too long delayed. Biology has proved that any living organism that tries to maintain itself in the presence of filth invariably dies. The board of trustees of the

# NEWS...

American Medical Association therefore calls on leaders of the medical profession in every community in which the association is represented to act promptly, remembering, however, the necessity for proceeding in due form by the filing of formal charges against physicians known to be participating in such methods, thus offering an opportunity for the presentation of evidence and a suitable hearing so that the innocent may not be harmed, but the guilty may be punished."

## Report Increase of 60.5 per Cent in Cost of Operation

RICHMOND, VA.—An increase of 60.5 per cent in the cost of operating the Medical College of Virginia Hospital from the fiscal year 1944-45 to 1946-47 was revealed recently in a survey of the specific effects of the rising costs of living on hospital operation, according to Dr. W. T. Sanger, president of the college.

The three major items in the jump in costs, Dr. Sanger said, were medical supplies, pay roll and food. The largest single increase, the survey showed, was in the cost of medical supplies and drugs, which advanced 150 per cent during the fiscal period. The next highest item was pay roll which increased 62 per cent during the same period. Food, next on the list, jumped 54 per cent in the two-year period.

The survey showed that financial problems of the hospital did not become acute until the spring of 1946, when rising costs began to have their effect. During the period of study, Dr. Sanger listed a striking increase in the demands for service. "For example," he said, "3000 more patients were admitted to the college hospitals in 1946-47 than in 1944-45 and were given 25,000 more days' treatment than were patients during the preceding years."



## A.D.A. Approves Internships

CHICAGO.—The American Dietetic Association has approved dietetic internships in Cook County, Michael Reese, University of Chicago and Hines Veterans' hospitals in the Chicago area, Lucille Refshauge, educational director of the association, announced last month.

The internships provided an opportunity for students to apply college training in dietetics in hospital work under supervision, it was explained. All interns accepted for training are graduates of accredited colleges or universities in food and nutrition or institution management. Completion of the internship qualifies a student for a position as a hospital dietitian, Miss Refshauge said.

## Fire Destroys Lutheran Home

MADRID, IOWA.—The Lutheran Home for the Aged here was destroyed by fire last month without loss of life. Sixty-three men and women patients were safely evacuated from the home after the fire was discovered, it was reported. Members of the board estimated the loss at $200,000.

Iowa Lutheran Hospital, Des Moines, and other hospitals in the Madrid area have offered to provide facilities to care for evacuated patients until permanent arrangements for their care can be made.

# 44...
## OF NEMBUTAL'S CLINICAL USES

**SEDATIVE**

**Cardiovascular**
Hypertension[1]
Coronary disease[1]
Angina[1]
Decompensation
Peripheral vascular disease

**Endocrine Disturbances**
Hyperthyroid
Menopause—female, male

**Nausea and Vomiting**
Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

**Gastrointestinal Disorders**
Cardiospasm[2]
Pylorospasm[2]
Spasm of biliary tract[2]
Spasm of colon[2]
Peptic ulcer[2]
Colitis[2]
Biliary dyskinesia

**Allergic Disorders**
Irritability
To combat stimulation of ephedrine alone, etc.[3,1]

**Irritability Associated With Infections[4]**

**Restlessness and Irritability With Pain[5,4]**

**Central Nervous System**
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

**Anticonvulsant**
Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

**HYPNOTIC**
**Induction of Sleep**

**OBSTETRICAL**
**Nausea and Vomiting**
**Eclampsia**
**Amnesia and Analgesia[6]**

**SURGICAL**
**Preoperative Sedation**
**Basal Anesthesia**
**Postoperative Sedation**

**PEDIATRIC**
**Sedation for:**
Special examinations
Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery

**Preoperative Sedation**

*Nembutal alone or [1]Glucophylline® and Nembutal, [2]Nembutal and Belladonna, [3]Ephedrine and Nembutal, [4]Nembudeine®, [5]Nembutal and Aspirin, [6]with scopolamine or other drugs.*


Many and varied, too, are the uses of short-acting Nembutal. Since it may now be your barbiturate of choice in one or more conditions, perhaps you have considered the advantages of enlarging your experience with Nembutal in other conditions—as more and more physicians are doing. Their rationale is sound. They are familiar with the doses needed to achieve any desired degree of cerebral depression, from mild sedation to deep hypnosis. They know that the dosage required is small, about *one-half* that of many barbiturates . . . that, with this small dosage, the duration of effect is shorter . . . the amount of drug to be inactivated is less . . . the possibility of after-effect is reduced . . . the margin of clinical safety is wide. In cases where Nembutal is indicated, won't you give it a trial in conditions besides those for which you are now using it? There are 11 Nembutal products available at your pharmacy, all in convenient small-dosage forms. ABBOTT LABORATORIES, North Chicago, Illinois.

***In equal oral doses, no other barbiturate combines* QUICKER, BRIEFER, MORE PROFOUND EFFECT *than...***

# Nembutal®

**(Pentobarbital, Abbott)**

*HAVE YOU TRIED Nembutal Sodium Suppositories, or palatable Nembutal Elixir, when it is not possible or feasible to give other dosage forms?*

# NEWS...

## PROJECT APPLICATIONS APPROVED BY U.S.P.H.S.

(*Continued From Page 122.*)

| State and Project | Desc. | No. Beds | Ownership | Est. Tot. Cost | Est. Fed Share |
|---|---|---|---|---|---|
| *OKALAHOMA—Continued* | | | | | |
| Cimarron County Hospital<br>Boise City | Gen. | 16 | Pub. | 182,630 | 59,876 |
| Stillwater Municipal Hospital<br>Stillwater | Gen. | 50 | Pub. | 344,500 | 114,833 |
| Community Hospital<br>Kingfisher | Gen. | 20 | N.-P. | 160,000 | 50,000 |
| *TEXAS* | | | | | |
| Shackelford County Memorial Hospital<br>Albany | Gen. | 16 | Pub. | 110,525 | 36,500 |
| Uvalde County Hospital<br>Uvalde | Gen. | 40 | Pub. | 378,900 | 126,300 |
| Gray County Hospital<br>Pampa | Gen. | 90 | Pub. | 1,003,000 | 333,333 |
| Lee Memorial Hospital<br>Giddings | Gen. | 16 | N.-P. | 132,600 | 42,200 |
| San Saba County Hospital<br>San Saba | Gen. | 22 | Pub. | 232,500 | 75,666 |
| Goliad County Hospital<br>Goliad | Gen. | 14 | Pub. | 127,500 | 41,166 |
| Calhoun County Hospital<br>Port Lavaca | Gen. | 20 | Pub. | 227,000 | 75,000 |
| Norton Memorial Health Center<br>Port Arthur | P.H.C. | 0 | Pub. | 97,800 | 32,600 |
| Bexar County Hospital<br>San Antonio | T.B. | 100 | Pub. | 342,108 | 114,036 |
| Huntsville Memorial Hospital<br>Huntsville | Gen. | 32 | Pub. | 370,000 | 115,000 |
| Mason Memorial Hospital<br>Mason | Gen. | 10 | Pub. | 90,600 | 30,200 |
| Edwards County Hospital<br>Rocksprings | Gen. | 10 | Pub. | 112,600 | 37,500 |
| Tyler County Hospital<br>Woodville | Gen. | 23 | Pub. | 225,000 | 75,000 |
| Hardin County Hospital<br>Kountze | Gen. | 50 | Pub. | 455,000 | 150,000 |
| Trinity Memorial Hospital<br>Trinity | Gen. | 14 | N.-P. | 100,000 | 33,333 |
| Sarah Cartmell Memorial Hospital<br>Palestine | Gen. & Lab. | 60 | Pub. | 594,900 | 193,300 |
| Dimmit County Hospital<br>Carrizo Springs | Gen. & P.H.C. | 30 | Pub. | 301,400 | 100,000 |
| Hudspeth County Hospital<br>Sierra Blanca | Gen. | 12 | Pub. | 148,143 | 49,214 |
| Mauritz Memorial Hospital<br>Ganado | Gen. | 28 | Pub. | 316,500 | 105,500 |
| *WASHINGTON* | | | | | |
| Willapa Harbor General Hospital<br>South Bend | Gen. | 30 | Pub. | 384,340 | 127,791 |

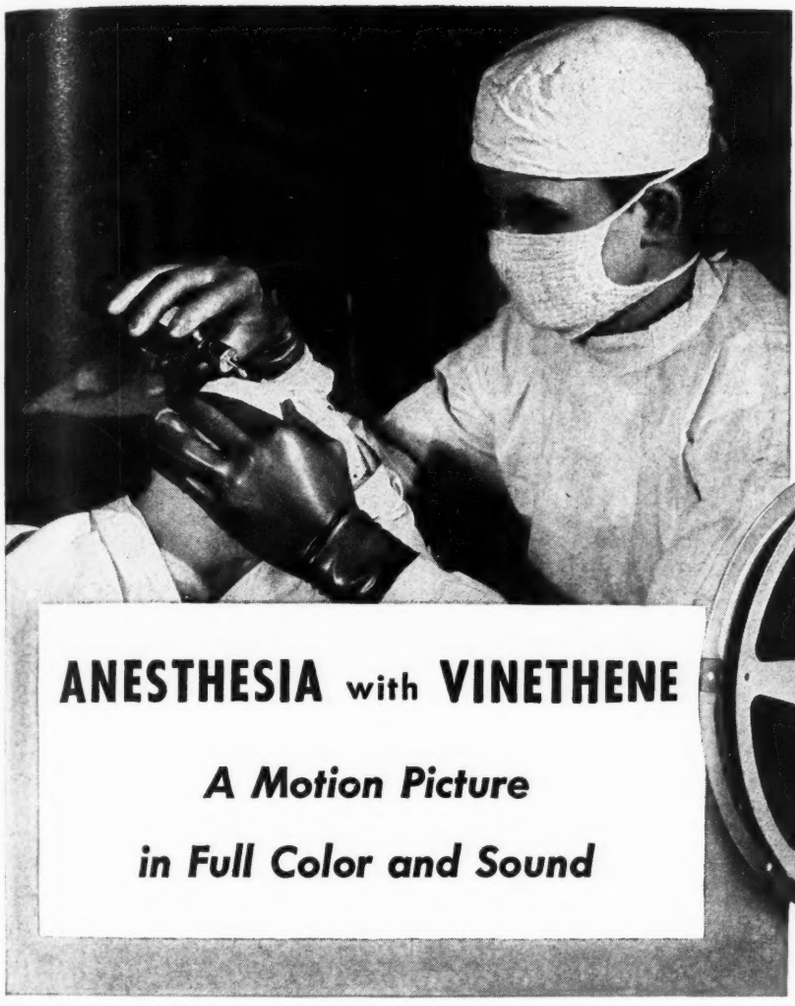
## Colorado Man Cited as Outstanding G.P. at A.M.A. Session

CLEVELAND.—Dr. Archer C. Sudan of Kremmling, Colo., was awarded a special gold medal in recognition of his service as an outstanding general practitioner at the interim session of the American Medical Association here last month. The session was devoted especially to the interests and problems of the family doctor.

In accepting the award and the gold medal which accompanied it, Dr. Sudan stated that he welcomed the "public awakening to the doctor's need for modern facilities."

"I believe this is a community responsibility," the Colorado practitioner declared. "I am happy to know that many small towns and rural areas are now building their own community hospitals with their own community funds As these hospitals develop and provide facilities for the doctor, modern general practitioners will welcome the opportunity to practice in such areas, and that will solve the biggest problem in the distribution of medical care."

Federal Security Administrator Oscar R. Ewing told A.M.A. delegates that he would try to put the greatest possible number of modern medical and hospital resources at the disposal of the general practitioner.



# ANESTHESIA with VINETHENE

## *A Motion Picture in Full Color and Sound*

This interesting motion picture is available for loan to anesthesiologists and other professional groups interested in anesthesia. It is a 16 mm. Kodachrome, sound track film of one reel, with a running time of 25 minutes. A sound projector is required for its showing.

This film portrays the proper technic for administration of Vinethene and the precautions to be observed in using this rapidly acting inhalation anesthetic. Methods of administration for short medical and dental operative procedures, as an induction agent prior to ethyl ether, and as a complement to nitrous oxide-oxygen, are demonstrated.

*Please forward requests to:*
MERCK & CO., Inc.
*Attention: Film Loan Service*
RAHWAY, N. J.

VINYL ETHER FOR ANESTHESIA U. S. P. MERCK

# VINETHENE

REG. U. S. PAT. OFF.

*An Inhalation Anesthetic for Short Operative Procedures*

COUNCIL ACCEPTED

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

*In Canada:* Merck & Co., Ltd., Montreal, Que.

# NEWS . . .

## Army Announces New Commissioning Policy

WASHINGTON, D. C.—The army announced a policy effective December 15 of commissioning medical officers in advanced grades up to and including that of colonel. Eligible to apply for regular army commissions are civilian physicians and dentists with no previous military experience, as well as members of the National Guard, reserve corps and A. U. S.

A physician or dentist with no professional experience who is under 32 is eligible to become a first lieutenant.

Applicants who possess outstanding qualifications for special positions will be appointed in the grade of colonel.

Maj. Gen. Raymond W. Bliss, surgeon general of the army, has announced the establishment of a special procurement branch in the personnel division.



## Asks $300,000,000 Fund

NEW YORK.—More beds for chronic disease, tuberculosis and cancer were named as the first need in New York's municipal hospital system by Dr. Edward M. Bernecker, hospital commissioner, in a recent public address urging support of the mayor's program for financing city health and hospital needs.

Appropriations totaling more than $300,000,000 were requested by Dr. Bernecker for necessary hospital expansion and modernization. An additional need for funds to expand the hospital pay roll was outlined.

## Plan New Regional Group

HARRISBURG, PA.—A new regional hospital group, including state associations of Pennsylvania, New York, New Jersey, Delaware, Maryland and the District of Columbia, was envisioned in an action by the board of trustees of the Hospital Association of Pennsylvania, meeting here recently. The board authorized the association's president and executive secretary to invite officers of the neighboring associations to a meeting in Philadelphia for the purpose of discussing ways and means of holding a regional convention after 1948.

## Institute for Librarians

CHICAGO.—The council on professional practice of the American Hospital Association in cooperation with the American Association of Medical Record Librarians conducted an institute for medical record librarians in Milwaukee the week of January 26. Subjects for the lecture and seminar sessions included basic principles of nomenclature, analysis of medical records, medical and hospital ethics, the medical audit and relationship of the record library to other departments.

## Gift to Bingham Fund

BOSTON.—A gift of $300,000 to the Bingham Associates Fund was made last month by Jacob Ziskind, Fall River, Mass., industrialist. The Bingham Fund supports the New England medical center, including the Pratt Diagnostic Hospital, Boston Floating Hospital, Boston Dispensary and Tufts Medical School. The gift was made as a means of "aiding humanity through medical research," Mr. Ziskind announced.

## ABOUT PEOPLE

(*Continued From Page* 84.)

**George Ahearn** has been appointed superintendent of Clark County Memorial Hospital at Jeffersonville, Ind., succeeding **Kenneth M. Pierce,** who resigned.

**Van C. Adams,** who resigned as administrator of Jewish Hospital, Cincinnati, after seven years of service, has been selected as head of Alexandria Hospital, Alexandria, Va., succeeding **Robert G. Whitton.**

**Murray Sargent** for the last fourteen years director of New York Hospital has resigned. **Laurence G. Payson,** secretary-treasurer of the institution, will serve as acting head until a permanent director has been selected. Mr. Sargent will retain his interest in the institution, serving as an honorary member of the board.

### Department Heads

**Dr. Kenneth E. Latterell,** who recently completed a three year residency in anesthesiology at Mayo Clinic, Rochester, Minn., has assumed his new duties as director of the department of anesthesiology and of the school of anesthesia at Creighton Memorial, St. Joseph's Hospital, Omaha, Neb. At the same time it was announced that **Sister M. Rosita Billesbach, O.S.F.,** has been named medical record librarian at the hospital, succeeding **Sister M. Edmondine Kudlacz, O.S.F.,** who has been transferred to St. Anthony Hospital, Denver, in an exchange of places with Sister Rosita.

**Mary E. Johnson, R.N.,** has been appointed director of nursing and principal of the school of nursing at Concord Hospital, Concord, N. H. She was formerly director of nursing services at Ellis Hospital, Schenectady, N. Y.

**Frances L. Ware,** former director of dietetics at St. Luke's Hospital, Chicago, has accepted a similar post at Rhode Island Hospital, Providence, R. I.

**Dr. S. Howard Armstrong Jr.** of Boston has been appointed chairman of the department of medicine at Presbyterian Hospital, Chicago. He will devote the greater part of his time to the planning and direction of the hospital's enlarged program of medical research and education.

**Marie L. Casteen** has been appointed chief dietitian of Newton-Wellesley Hospital, Newton Lower Falls, Mass. Miss Casteen succeeds **M. Isabel Foster** who resigned to accept the position of chief dietitian at Ochsner Medical Foundation, New Orleans.

**Louise Hostman,** Illinois Training School, Chicago, has resigned after twenty years as night supervisor at the University of Chicago Clinics. **Mary Enright,** formerly of Midway and Mounds Park Hospital, St. Paul, has been appointed to fill this vacancy.

### Miscellaneous

**Mark Dexter Hollis** has been appointed assistant surgeon general and chief of the sanitary engineering division, U. S. Public Health Service, **Dr. Thomas Parran,** the surgeon general, has announced. Mr. Hollis replaces **John Kurtz Hoskins** who retired after thirty-four years with the service. **Harry Glenys Hanson,** assistant to the surgeon general, succeeds Mr. Hollis as executive officer in the office of the surgeon general.

Mr. Hollis was transferred to his present position from the communicable disease center, Atlanta, Ga., where he was officer in charge. Under his leadership, the center developed the country's most comprehensive program for the control of malaria, typhus and other diseases spread by zoological vectors. During the war, he directed a similar program designed to prevent the spread of malaria and typhus fever among military and war industrial personnel in the United States. Other positions held by Mr. Hollis during ten years of duty with

the Public Health Service include the organization of a nationwide survey of typhus fever and stream pollution investigations for the Office of Stream Sanitation, Cincinnati, and the Chesapeake Bay Pollution Survey, Norfolk.

**Everett W. Jones,** vice president of The Modern Hospital Publishing Company, has been appointed associate director of the Northwestern University program in hospital administration in charge of internships.

**Dr. W. Paul Briggs,** chief of the Veterans Administration pharmacy division, has resigned his position. He had been with V.A. since March 1946.


Rev. Curry

**Rev. John J. Curry** has been appointed director of the division of health and hospitals of New York Catholic Charities to succeed the **Very Rev. Msgr. John J. Bingham,** recently appointed to the pastorate of St. Patrick's Church, Yorktown Heights, N. Y. Father Curry has served as assistant director of the division of health and hospitals since 1939. He is a member of the American Hospital Association, the Catholic Hospital Association and the health committee of the National Conference of Catholic Charities, among other organizations.

**Leonard P. Goudy,** former superintendent of Saskatoon City Hospital, Saskatoon, Sask., has joined the headquarters staff of the American Hospital Association as purchasing specialist. At the same time **Mrs. Emily K. Johnson,** former public relations director for the Nursing Information Bureau, was named to assist in the association's expanded nurse recruitment program.

## Deaths

**Frances Stern,** founder of the world's first food clinic and an internationally known nutritionist, died at her home in Newton, Mass., at the age of 74. Since 1918 Miss Stern has been identified with the Food Clinic at the Boston Dispensary and recently a special chair in nutrition was endowed in her name at the Tufts Medical College on whose faculty she served.

**Dr. Willis G. Nealley,** director emeritus of Brooklyn Hospital, Brooklyn, N. Y., died January 7 of a heart ailment. Dr. Nealley was director of the hospital for thirty-four years. While he was its head the hospital was tripled in size and its professional staff was enlarged. In 1937, Dr. Nealley was instrumental in organizing the Greater New York Hospital Association by uniting the Hospital Council of Brooklyn and the Hospital Conference of the City of New York.

**Sister Perpetua,** former superintendent and Superior of St. Agnes Hospital, White Plains, N. Y., died at that institution at the age of 73. Sister Perpetua founded St. Francis Hospital in Poughkeepsie, N. Y., in 1913 and later founded St. Mary's Hospital, Orange, N. J.

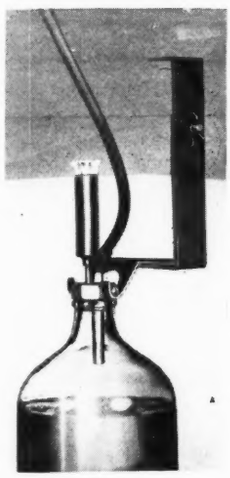
**Dr. Max Pinner,** 56, an authority on pulmonary diseases and, since 1939, editor of the *American Review of Tuberculosis,* died January 7. He had formerly been chief of the division of pulmonary diseases at Montefiore Hospital in New York City and the Montefiore Sanitarium at Bedford Hills, N. Y.

**Clarence L. Neu,** president of the Physicians' Record Company, Chicago, died of a heart ailment at the Ravenswood Hospital on January 16. A publisher of books, pamphlets and record forms for doctors and hospitals, Mr. Neu was well known to hospital people throughout the country. Notable among the works published by the Physicians' Record Company are "Hospital Organization and Management" by Dr. MacEachern, "The Medical Staff in the Hospital" by Dr. T. R. Ponton, "Hospital Public Relations" by Alden B. Mills, and "Hospital Color and Decoration" by Raymond P. Sloan.

# What's New for Hospitals

FEBRUARY 1948 SUPPLEMENT TO THE MODERN HOSPITAL

### Tomac Deodorizing Drainage Bottle



The new Tomac deodorizing drainage bottle is designed to neutralize and deodorize exudate odors where constant drainage is necessary. The bottle hangs securely under the patient's bed, out of his view, and suspended approximately 4½ inches from the floor to prevent interference with cleaning. A small sponge saturated with Aero-Klenz Deodorant fits into the top of the bottle, automatically deodorizing air leaving the container. Thus safe drainage is provided without air contamination. **American Hospital Supply Corp., Dept. MH, 2020 Ridge Ave., Evanston, Ill. (Key No. 3933)**

### Horn-O-Kote

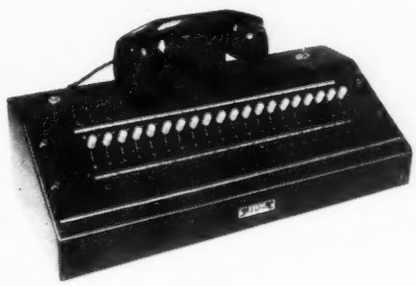
Horn-O-Kote is a coating for cement asbestos shingles and siding to renew the appearance and cover all streaks, stains and soiled areas. It was especially developed for this purpose and is a coating that actually bonds chemically and physically to the asbestos shingles. It is ready mixed, requires no thinner and one gallon covers approximately 300 square feet. **A. C. Horn Co., Inc., Dept. MH, 43-36 Tenth St., Long Island City 1, N. Y. (Key No. 3934)**

### Improved Kotex Pad

Kotex hospital pads have been redesigned for greater absorbency and efficiency. The new pad has an outer shell of cellucotton wadding, an inner section of cellucotton fluff which is a soft absorbent material with increased capacity for retention of drainage, and an "equalizer strip" of cellucotton in the center which is so constructed that moisture is distributed throughout the full length of the pad. The new pads withstand steam sterilizing or autoclaving with no loss of fluffiness or absorbency. **Bauer & Black, Dept. MH, 2500 S. Dearborn St., Chicago 16. (Key No. 3935)**

### Nurse-Patient Communication

The new IBM two-way communicating unit enables the nurse to make immediate response to a patient's signal, thus reassuring the patient and saving nursing time, and also permits sound supervision of patients at any time. When the patient presses the nurses' call button, a control panel at the nursing station or chart desk shows a signal for the room. The nurse establishes communication by operating the key on her desk unit corresponding to the incoming pilot light. She can then hold a conversation with the patient by using the cradle-type phone.



A loud-speaker type of communicating unit at the patient's bedside or mounted on the wall above the bed makes it possible for the patient to speak to the nurse once the latter has answered the signal. A "confidential" switch on the patient's unit can be placed in an "off" position in which case the nurse at the control unit is unable to pick up conversation in the patient's room, thus ensuring the patient privacy when desired. A signal at the nursing desk indicates that the switch is off.

With this system the night nurse can check patients to determine whether they are breathing normally and sleeping restfully. Where a patient is seriously ill the circuit can be kept open and the nurse can have constant check by merely opening her key. **International Business Machines Corp., Dept. MH, 590 Madison Ave., New York 22. (Key No. 3936)**

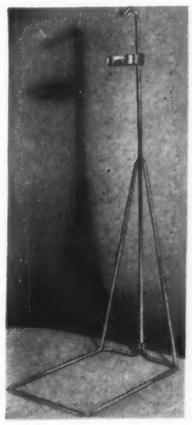
### Pipette and Thermometer Racks

Pipette and thermometer racks of a new design have recently been announced. Made of steel rod framework with the rods on opposite sides crimped at equal intervals to hold pipettes and thermometers safely for easy access, the racks are made in both stainless steel and polished nickel plated steel. The ends and sides of the racks slope slightly inward for increased stability and all joints are welded.

The pipette rack is 7 inches high and 13¼ by 8¾ inches at the bottom. It has space for 30 pipettes. The rack for clinical thermometers is compact and sturdy and particularly adapted for hospital use. It has space for 20 thermometers 4 and 5 inches long, of all diameters. The laboratory thermometer rack is designed to hold 14 thermometers 12, 14 and 16 inches long. **Ballo Instrument Co., Dept. MH, 30 Church St., New York 7. (Key No. 3937)**

### Lundy Portable Intravenous Stand

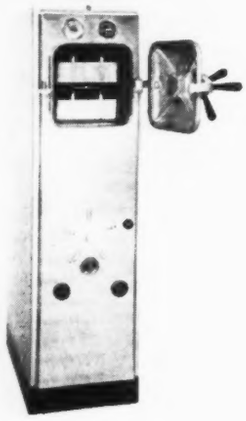
The new Lundy portable intravenous stand is designed to hold a container of intravenous solution at the bedside or while the patient is being moved to or from the operating room or other treatment center. The upright is equipped with a hood for the bail of the solution container and a rubber-covered yoke prevents the container from swinging when the patient is being moved. The stand has a 3 leg upright, 34 inches high, attached to a base 10 by 14 inches which extends under the mattress or pad and is held in place by the weight of the patient. **The Ohio Chemical & Mfg. Co., Dept. MH, Madison 4, Wis. (Key No. 3938)**





*Address manufacturers for further information and prices—or use Readers' Service blank on page 248*

### Improved Instrument Sterilizer



The pressure instrument washer-sterilizer was developed to eliminate the necessity for hand scrubbing of instruments following their use in surgery. With this device instruments can be taken from the site of operation, washed and sterilized and returned for use or storage within a matter of minutes. With the new, improved model, two complete sets of instruments for a normal laparotomy can be washed and sterilized in approximately 15 minutes, thus affording considerable saving in nurses' time as well as energy. If desired, the equipment can be used as a conventional pressure instrument sterilizer without involving the complete washing process. The machine is so engineered from the angles of simplicity of operation, efficiency and safety that it can be handled by a relatively inexperienced nurse or other worker, an advantage with the present shortage of nursing personnel.

Features of the new design include a condenser vent which cools the steam after sterilization is completed and passes it off in the ordinary waste line as water, thus making it unnecessary to place the machine immediately adjacent to vent pipes for releasing steam; also one rotary control valve is used to set the positions for the washing and sterilizing processes, indicated by positive signals, thus giving automatic action to the whole operation. **American Sterilizer Co., Dept. MH, Erie, Pa. (Key No. 3939)**

### Hemostatic Absorbable Surgical Dressings

Hemo-Pak is a new absorbable oxidized gauze or cotton supplied in the form of sterile packing strips or cotton pads for use in the control of capillary or venous bleeding or small arterial hemorrhage during surgery. It is absorbed between the second and seventh days following implantation of the dry material. When exposed to the blood, hemostatis occurs so that the product forms an artificial clot or cork in the wound.

Hemo-Pak is supplied in sterile form in 14 by 2 inch gauze strip, 6 by 2 inch cotton pads and ½ inch by 2½ yard gauze packing strip. It is packed in boxes of twelve packages. **Johnson & Johnson, Dept. MH, New Brunswick, N. J. (Key No. 3940)**

### Electroconvulsive Therapy Unit

Described as especially effective in reducing both the number of cases of respiratory embarrassment following treatment and the initial tonic contraction after the application of current, the new Gilson Electroconvulsive Therapy unit is designed for maximum safety to the patient. The patient circuit is automatically turned off in case of failure of any part of the circuit.

The controls are simple and easily read. A selector switch controls the duration of treatment and there are also a main switch and its pilot light, a treatment switch and pilot light that

glows only when this switch is depressed, and a meter. Cord, rubber headband and electrodes fit in a compartment at the unit's base. It is compact, 8 by 12 by 12 inches in size, and weighs 25½ pounds. **Burdick Corp., Dept. MH, Milton, Wis. (Key No. 3941)**

### Filmo 8 mm. Motion Picture Camera

Hospitals taking moving pictures of surgical procedures, nursing technics and other activities for teaching or record purposes, as well as pictures for public relations and recreational uses, will want to look into the new Filmo Auto-8, 8 mm. camera recently announced by Bell & Howell. The new camera has a two-lens turret, lens-seating arrangement, magazine loading and ejector system, audible and visible footage indicators and five operating speeds. **Bell & Howell Co., Dept. MH, 7100 McCormick Rd., Chicago 45. (Key No. 3942)**

### Universal Infusion Standard

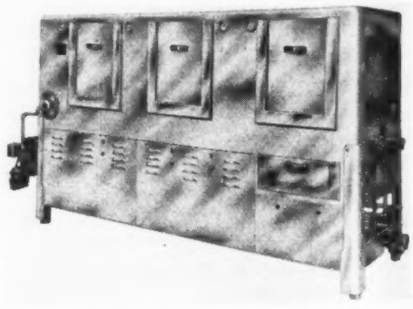
The Universal Infusion Standard is designed for infusion administration while the patient is in bed or while being transported on wheeled stretchers. The holding clamp fits either square, angular or round uprights of a bed or stretcher and the holding rod is adjustable in height and position. The unit can be quickly and easily transferred from the bed to the stretcher or vice versa and no floor standard is needed for intravenous administration in either case.

The standard accommodates various sizes and types of fluid bottles directly or with suspension basket. It is made of stainless steel and treated aluminum and is corrosion and stain resistant. **Custom Products, Inc., Dept. MH, P.O. Box 937, Nashville 2, Tenn. (Key No. 3943)**

### Colt Autosan R-100 Machine

The new Autosan R-100 dishwashing and sanitizing machine has a built-in soil removing section which operates as an integral part of the machine. Sixteen spray nozzles, eight above and eight below the conveyor, operate automatically to preflush soiled dishes with a lukewarm shower. Heavy soil is thus swept into the deep drawer-type scrap tray from which it passes into the waste line, thus leaving practically nothing to contaminate the wash solution. Soil is easily removed from the scrap tray by means of a sliding door at the front of the hood.

A built-in automatic start and stop mechanism on the heavier conveyor prevents damage in case of obstruction. Individual motor and pump units for wash and rinse tanks are mounted each on a single pedestal base, a magnetic switch is provided for control of each motor and provision is made for free circulation of air to keep motors cool. Other improvements in the new model R-100 include welded hood and tank, dial-type temperature gauges for each operation, tanks individually heated with separate steam injector and valve and a



removable end plate to facilitate cleaning. **Colt's Manufacturing Co., Dept. MH, Hartford 15, Conn. (Key No. 3944)**



*Address manufacturers for further information and prices—or use Readers' Service blank on page 248*

### Portable Incinerator

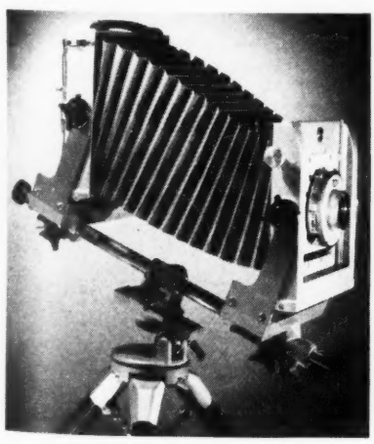
The new Plibrico Portable Incinerator is designed for the safe and easy disposal of wet or dry refuse. Made in three sizes with grate widths of 24, 36 and 48 inches, the new incinerator is a steel-cased unit, finished in aluminum paint, shipped complete and ready to operate when connected to a suitable stack or breeching. It can be easily moved as changing conditions require and a steel stack of the proper height and diameter can be furnished as optional equipment. An auxiliary gas burner is also available where a large proportion of wet refuse is to be burned. **Plibrico Jointless Firebrick Co., Dept. MH, 1800 Kingsbury St., Chicago 14. (Key No. 3945)**

### Sperzel Toilet Seat

A new self sustaining hinge that exerts a gripping action on both toilet seat and cover makes it impossible for the new Sperzel toilet seat to slam down on the bowl. Either the cover or the seat, or both together, can be raised to any desired position where they will remain until pushed down. The new seat is made of solid plastic in a number of types. **Sperzel Co., Dept. MH, 123 Fourteenth Ave. S., Minneapolis 4, Minn. (Key No. 3946)**

### Eastman View Camera

The new Eastman 4 by 5 view camera has many new features, including a revolving back which may be used for picture taking not only in the horizontal and vertical positions but at any point throughout a complete circle; a special ground glass release handle which relieves all tension on the ground glass and makes it possible to insert or remove film holders easily without jarring the camera; a standard monorail track 19 inches long, permitting a 15 inch



bellows extension; a swing front as well as back, and spirit levels on both top and side of camera to assure perfect camera alignment. It is designed to use standard film or plate holders as well as film pack adapters.

A full line of Kodak Ektar lenses, lumenized with Kodak's new hard coating for air-glass surfaces to reduce inner reflections and improve tone separation in the shadows, is available in focal length from 4 to 12 inches. Each lens is tested for exact register of the images of the three primary colors. The camera frame is of satin-finished aluminum and has a gray carrying case in which space is provided for accessories. **Eastman Kodak Co., Dept. MH, Rochester 4, N. Y. (Key No. 3947)**

### Public Room Furniture

Sectional units designed especially for use in furnishing lobbies, waiting rooms and other areas occupied by the public have been developed by Hill-Rom. The furniture is built for the hard wear expected in public rooms and is designed for easy maintenance and attractive appearance. The pieces are available either with slip covers or with a permanent

type of upholstery, either fabric or composition leather.

The units are so designed that they can be arranged as settees seating either two or three, as individual chairs for grouping with tables or alone and in many other arrangements possible because of the flexibility of the designs. **Hill-Rom Co., Inc., Dept. MH, Batesville, Ind. (Key No. 3948)**

### Group Hearing Systems

A volume control unit for group hearing installations, such as central radio programs for hospital patients, has been announced. The unit is applied to the Telex Monoset, a new type headset with under-chin construction for individual listeners. The unit is easily slipped into the ears.

The volume control unit on the main cord not only permits the patient to control his listening but is a convenience for the hard-of-hearing person who can adjust the tone to his hearing level by a slight turn of the dial. **Telex, Inc., Dept. MH, 1370 Northwestern Bank Bldg., Minneapolis 2, Minn. (Key No. 3949)**

### Pictronic 200 Timeter

The Pictronic 200 MA x-ray control is a new development in x-ray in which both timing and milliamperage stabilization are done electrically. This permits a high degree of timing precision and milliamperage is kept constant regardless of severe current fluctuation in incoming lines. The control is of the monitor type, thus making all operations, beyond the selection of kilovoltage and timing, automatic.

Time scale, meters, safety signals and other indicating devices are grouped on a single panel which is protected behind a plate glass door. This panel is at eye level while the operating controls are on a panel within easy reach at hand level. The new Timeter is safeguarded in every operating phase to prevent exposure which would overload the x-ray tube. **Picker X-Ray Corp., Dept. MH, 300 Fourth Ave., New York 10. (Key No. 3950)**

### Westinghouse Water Coolers

Westinghouse is announcing a new line of seven hermetically-sealed water coolers designed to meet every need. They will feature automatic pressure regulator for maintaining constant stream height regardless of variations of local water pressure, new type orifice on bubbler to prevent squirting and malicious water damage; foot pedal operation for convenience and sanitation and removable front panel for easier access to all mechanical parts.

The coolers will be finished in blue-gray enamel and except for one china top model, all units will have 1 piece, splashproof tops of stainless steel. Provision is made on the new models for adding a chrome plated glass filler where desired. The new line varies from one 3 gallon bottle type unit to pressure coolers varying from 3½ to 22½ gallon capacity. **Westinghouse Electric Corp., Dept. MH, 306 Fourth Ave., Pittsburgh 30, Pa. (Key No. 3951)**



*Address manufacturers for further information and prices—or use Readers' Service blank on page 248*

### Dazor Floating Magnifier

Magnification and illumination are combined in one unit in the Dazor Floating Magnifier. The Universal Model, illustrated, is designed to be attached to any surface and a portable pedestal model on a floor stand is also available.

The unit provides a flexible arm which can be moved over the area to be treated, studied or worked with, depending upon the use to which it is being put. The double convex type lens, made of high quality optical glass, is 5 inches in diameter and has a focal length of 13 inches and a power of 3 diopters. Three T5 6 watt fluorescent tubes provide soft, cool light directly on the object under examination. The magnifier head is entirely flexible and can be positioned at any angle by a touch of the hand, held firmly in that position by the Dazor Floating Arm until again moved. **Dazor Mfg. Corp., Dept. MH, 4481 Duncan Ave., St. Louis 10, Mo. (Key No. 3952)**

### Vestal Wax Remover

Old wax can be removed from floors without injury or damage to linoleum, asphalt tile, rubber tile, terrazzo, cement or wood with the new Vestal Wax Remover. The product also cleans the surface, leaving a slight, protective film. It is available in containers ranging from 5 to 55 gallons. **Vestal, Inc., Dept. MH, 4963 Manchester Ave., St. Louis 10, Mo. (Key No. 3953)**

### Rubberized Dampcoat Enamel

Wilbur and Williams' Dampcoat enamel has now been rubberized to resist moisture, chemicals, constant washings and fungus. It is designed for satisfactory use on cold, damp or wet surfaces in storage rooms, shower rooms, kitchens, basements and similar locations. At the same time it is a high gloss enamel which dries in approximately one hour and can be applied by brush or spray.

Known as Rubberized Dampcoat Enamel, the coating is practically odorless and contains no ingredients to affect food products. It can be used in sub-zero temperatures or on steam pipes. It is resistant to food acids and to alkaline cleaners. One gallon covers approximately 350 to 450 square feet, depending on porosity, and it is available in black, white, light gray, aluminum and eight colors. **The Wilbur & Williams Co., Dept. MH, Boston 15, Mass. (Key No. 3954)**

### All-Service Can

The new Lawson 200 All-Service Can is suitable for waste disposal or for food or other storage. The mushroom type cover prevents the escape of odors and also closes the can tightly enough to make it suitable for storage purposes.

The can has a drawn rounded bottom and all welded seams which provide smooth edges inside for easy cleaning. Both can and cover are sturdily constructed for long, hard wear and the


large rolled rim at the top gives added strength. A welded on, rounded steel ring at the bottom acts as a floor-protecting skid and the can has two handles for easy carrying.

Made of 18 gauge black steel, dip galvanized, the can is available with or without cover. It is 24 inches high, without cover, and 18 inches in diameter. **The F. W. Lawson Co., Dept. MH, Cincinnati 4, Ohio. (Key No. 3955)**

### Penetrating Floor Sealer

The new Vita-Var penetrating floor sealer and wood finish penetrates deeply into wood, sealing pores so that dust, dirt and grime are easily cleaned off. It leaves no surface film and produces a satiny, non-slippery finish on any type of wood floor or woodwork. It is designed to retard warping, cracking and splintering and is available in both clear and stained finish. **Vita-Var Corp., Dept. MH, Newark, N. J. (Key No. 3956)**

### Amcolun Safety Tile

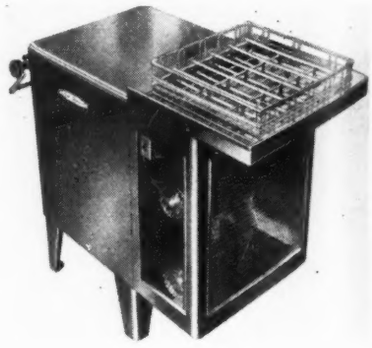
Amcolun Safety Tile combines safety, durability, weight economy and cleanliness. A homogeneous, compact structure, Amcolun is composed of abrasive material and other inert fillers evenly distributed and bonded together. The abrasive used assures long wear in addition to a slip-proof surface. The tiles are resistant to shock impact even though light in weight.

This new tile can be applied over existing wood, concrete or steel floors and is especially adapted for use in showers, dressing rooms, laboratories and other areas where safe footing is required as well as a floor resistant to acids, alkalies, water and oil. The tile is unaffected by weather, thus making it ideal for outdoor use. It is available in red or green, in 6 or 9 inch squares. **American Abrasive Metals Co., Dept. MH, Irvington, N. J. (Key No. 3957)**

### SalFrann "400" Dishwasher

The new SalFrann "400" dishwasher is designed to handle 34 full racks of dishes per hour for washing, rinsing and air drying. The rack of dirty dishes, glasses or silverware is placed on the hydraulic lift track and lowered automatically into the cleaning chamber. A turn of the electric switch starts the spray of cleansing detergent solution, the rinse lever releases a sterilization spray of hot rinse water and the turn of a handle brings the clean dishes to table level.

The machine is designed to clean dishes, glasses and silverware with ease and speed and be easily cleaned itself. Drainings are carried off through a direct sewer connection, strainer trays in the wash compartment catch and hold large particles, a removable screen protects the pump intake and the spray tubes are easily removed for cleaning. The flat top of the hydraulic lift encloses the cleansing unit from above during washing and rinsing and serves also as an additional service table top between



washing operations. **Thermo Cuber Co., Inc., Dept. MH, 3260 W. Grand Ave., Chicago 51. (Key No. 3958)**



***Address manufacturers for further information and prices—or use Readers' Service blank on page 248***

### Elevator Car Finishes

A choice of 61 colors is now available in the standard line of finishes for Otis Elevator car interiors. Sets of cards showing these finishes are available in all of the company offices. The colors are divided into four classes: solids; Metalusters, having a metallic sheen; Metaluster Hammertones, having a metallic sheen and an appearance of depth, and wood grains.

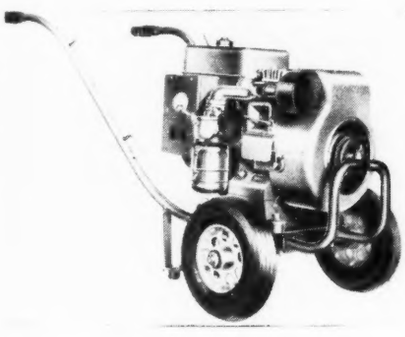
The standard Otis finishes differ in the glassiness of the final lacquered surface. "A" is a flat finish for use on canopies of cars with direct lighting; "AA" an extra flat finish for canopies of cars with indirect lighting and "B" a semi-gloss and "C" a high gloss are for car panels and other lacquered parts except canopies. The company offers helpful suggestions on colors and finishes best suited to each use, among them the recommendation that greens and green-blues in hospital elevator cars are more soothing and restful to passengers. **Otis Elevator Co., Dept. MH, 260 Eleventh Ave., New York 1. (Key No. 3959)**

### Non-Inflammable Paint Remover

Savogran Non-Inflammable Remover is designed to meet Federal specifications for non-inflammability and to remove all paint, varnish, shellac, enamel, lacquer and synthetic finishes. It is in heavy cream form that stays wet and stays in place on upright surfaces and requires no after wash to complete the removal. **The Savogran Co., Dept. MH, India Wharf, Boston 10, Mass. (Key No. 3960)**

### Ground Maintenance Electric Plant

Those responsible for the maintenance of grounds will be interested in the new AH series of portable electric plants especially designed to provide power for any electric gardening tool, universal, alternating or direct current, within their full rated capacity. Only one gallon of gasoline is required for more than four hours of operation under heavy load



conditions with the new plants.

Turf maintenance as well as trimming of bushes and trees can be powered through these units and repair work on any part of the grounds can be done with electric tools powered by the portable plants. **D. W. Onan & Sons Inc., Dept. MH, Minneapolis 5, Minn. (Key No. 3961)**

### Bactericide-Deodorant

Hyamine 1622, the quaternary ammonium compound originally developed as an all-purpose germicide, has been found to be effective as a deodorant. A solution of 0.1 to 0.5 per cent is the formula suggested for sponging or mopping surface odors and 0.05 per cent strength for space spraying to produce long lasting and effective deodorizing. The product is said to destroy rather than to conceal or mask unpleasant odors. **Rohm & Haas Co., Dept. MH, 222 W. Washington Square, Philadelphia 5, Pa. (Key No. 3962)**

### Toastmaster Waffle Baker

The new Toastmaster double unit waffle baker, Model 2E1, has a Thermo-

flex Control which automatically adjusts baking time according to the batter used. The waffle baker is snapped on and preheats automatically, ready for instant use. The adjustment button is set for the desired color in finished waffles and needs no further attention. When the batter is poured in and the cover closed, a pilot light comes on. When the waffle has reached the desired crispness, the light automatically goes off, indicating that the waffle is ready for serving.

The Toastmaster Waffle Baker is modern in design and heavily chromium plated. The grids are of extra heavy, porous cast aluminum, to minimize the possibility of sticking, and the heating elements are practically indestructible. The unit is available in all standard voltages and operates on either AC or DC. **Toastmaster Products Div., McGraw Electric Co., Dept. MH, Elgin, Ill. (Key No. 3963)**

### High-Speed Laundry Drying Tumbler

Designed for economical mass production drying of all laundered work, the new American High-Speed Drying Tumbler has multiple fans, full-length, double banked heating coils, and automatically reversing cylinder with large air-circulating areas. Balance of the three factors has been carefully engineered to achieve rapid drying.

The tumbler is operated through a simple, push-button control and the single-latch case door is counterbalanced for easy opening. The door is interlocked with the electro-mechanical brake and cylinder and fan motors. Opening the case door automatically stops the motors and applies the brake. Indicator dial enables the operator to spot the cylinder door for unloading without opening the case door. The thermostatic damper control automatically admits hot or room-temperature air to the load as needed. A light signals the operator when the load is ready to be removed. The unit is especially designed for simple, safe operation. The **American Laundry Machinery Co., Dept. MH, Cincinnati 12, Ohio. (Key No. 3964)**

### Coin-Operated Radio

A new coin-operated radio has been designed and engineered with the special needs of hospitals, where reception conditions are usually difficult, in mind. It operates either with a regular speaker for private rooms, the volume of which is preset to prevent disturbing other patients when the main speaker is used, or with an "under the pillow" speaker for wards or semi-private rooms.

The hospital Tradio is a 6 tube, all-aluminum table model radio finished in hard enamel in a large choice of colors, including white. The unit is designed to operate 3 hours for 25 cents but this may be changed to meet the requirements of individual hospitals. **Tradio, Inc., Dept. MH, Asbury Park, N. J. (Key No. 3965)**



*Address manufacturers for further information and prices—or use Readers' Service blank on page 248*

## Pharmaceuticals

### Thephorin

The new antihistamine drug, Thephorin, is designed for the symptomatic treatment of allergic disorders. Research has indicated it to be highly effective in relieving urticaria, allergic rhinitis, hay fever, allergic skin diseases and some cases of bronchial asthma; to have a mildly stimulating effect in some cases and unlikely to produce drowsiness, and to have a low incidence of side reactions. It is supplied in oral tablets, 25 mg. each, in bottles of 50 and 100, and as a palatable syrup, 10 mg. of Thephorin per teaspoonful, in 4 ounce and 1 pint bottles. **Hoffmann-La Roche Inc., Dept. MH, Nutley, N. J. (Key No. 3966)**

### Streptomycin Hydrochloride Squibb

Streptomycin Hydrochloride Squibb, active against certain gram-negative, gram-positive and acid-fast bacteria, is now available in two sizes of diaphragm-capped vials containing the equivalent of 1.0 Gm. or 2.0 Gm. of the pure streptomycin base. It is readily soluble in small amounts of pyrogen-free water or physiological saline solution in concentrations up to 250 mg. per cc. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 3967)**

### Zymadrops

Zymadrops has been developed to provide the needed 8 vitamin supplementation for breast-fed or formula-fed children and for adults who cannot swallow capsules. It is so concentrated that adequacy of every clinically established vitamin factor is afforded with drop dosage and the product is fully miscible with liquids or semiliquid foods. Each bottle provides a graduated dropper marked for dosage and the product supplies vitamins A, D, C and the B complex. **The Upjohn Co., Dept. MH, Kalamazoo 99, Mich. (Key No. 3968)**

### Soluble Tablets Crystalline Penicillin

The new Soluble Tablets Crystalline Penicillin are readily soluble in water, saliva, milk, saline solution and syrup. Each tablet contains 50,000 units of Crystalline Penicillin G Potassium entirely free from binders or excipients. They permit administration of measured quantities of penicillin when parenteral therapy is neither feasible nor indicated. They may be taken orally, sublingually, in infant formulas, in aerosol administration and other methods. The preparation is heat stable and requires no refrigeration and the tablets are supplied in boxes of 24, each sealed in aluminum foil. **C.S.C. Pharmaceuticals, Div. of Commercial Solvents Corp., Dept. MH, 17 E. 42nd St., New York 17. (Key No. 3969)**

### Stuart Therapeutic B Complex C

The new Stuart Therapeutic B Complex C tablets are designed to give high potencies of the entire B complex and vitamin C in a low cost tablet. Each tablet is standardized to contain 150 mgs. ascorbic acid, 20 mgs. thiamin chloride, 10 mgs. riboflavin, 5 mgs. pyridoxin HCl, 150 mgs. niacin amide, 10 mgs. calcium pantothenate and other members of the B complex as present in liver extract, including identified and unidentified factors. It is supplied in bottles of 50 tables. **The Stuart Co., Dept. MH, 234 E. Colorado St., Pasadena 1, Calif. (Key No. 3970)**

### Privine Change

Changes in the recommended use of the two concentrations of Privine have resulted in new labels as reminders. The 0.05 per cent solution will have a gray and maroon colored label and will be packaged in one ounce bottles for prescription use and in 1 pint bottles for the convenience of physicians and hospitals. The stronger 0.1 per cent solution will be packaged only in 1 pint bottles for the direct use of physicians and hospitals and will have a label in yellow and maroon. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N. J. (Key No. 3971)**

### Hemosules

A combination of iron, liver and vitamins for the treatment of secondary anemias is offered in the new Warner product Hemosules. This new hematinic preparation provides iron, liver concentrate anianemia factors, vitamin B complex, vitamin C and folic acid in capsule form. It is supplied in bottles of 96 and 250. **William R. Warner & Co., Inc., Dept. MH, 113 W. 18th St., New York 11, N. Y. (Key No. 3972)**

### Penicillin Dulcet Tablets

Penicillin is now available in Abbott's Dulcet Tablets, the candy-like tablets for use with children. Each tablet appears, tastes and smells like candy and contains 50,000 units of crystalline penicillin G sodium, buffered. They are cinnamon flavored and supplied in bottles of 12. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 3973)**

## Product Literature

• A new booklet on **"Infant Care"** has been issued by the U. S. Children's Bureau. The Bureau, in collaboration with the Council on Professional Practice, American Hospital Association, is recommending that this publication be distributed to new mothers while still in the hospital and has made a quantity price of $11.25 per hundred to hospitals for this purpose. The booklet is available from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Some state health departments are purchasing "Infant Care" in quantities for distribution to all hospitals within their states requesting copies, hence many administrators may be able to obtain a supply for their hospitals without cost through their state health departments. **(Key No. 3974)**

• The Third Edition of **"Diabetes Mellitus, Methods of Dietetic Management and the Use of Preparations of Insulin"** has been issued by Eli Lilly & Co., Indianapolis 6, Ind. Published for the medical profession, this 137 page, plus index, board-bound book covers the subject from basic principles to sample menus for specific prescription diets and other information. Color plates showing urine tests for sugar and how they are done, together with various helpful charts are also included in the book. **(Key No. 3975)**

• A new booklet on **"Aero-Klenz Deodorant Solution"** has been issued by Anderson-Stolz Pharmaceuticals, Inc., 1731 Walnut St., Kansas City 8, Mo. Detailed information on the problem of elimination of offensive odors in the hospital and the method of solving it is given, together with directions for using Aero-Klenz and data on the new Aero-Klenz Vornado Unit, Aero-Klenz deodorant top dressings and the Aero-Klenz Hand Dispenser. **(Key No. 3976)**

• **"Canned Foods in the Nutritional Spotlight"** is the title of a new reference booklet prepared as a result of a continuing study which is conducted at leading universities and is sponsored by the National Canners Association and the Can Manufacturers Institute. The information includes a series of charts which rank the foods according to the 6 chief vitamins, 3 minerals, fat, carbohydrate and protein and a tabulation providing a quick, easy reference to the component nutrients in the 41 most commonly used canned foods. Reasonable quantities of the booklet are available to professional personnel from the Can Manufacturers Institute, 60 E. 42nd St., New York 17. **(Key No. 3977)**



***Address manufacturers for further information and prices—or use Readers' Service blank on page 248***

• Information on **"Lysine, the Unique Essential Amino Acid"** is offered in an attractively laid out and printed booklet prepared by the Biochemical Div., Interchemical Corp., Union, N. J. Data includes chemistry and metabolism of Lysine, Lysine content of foods, effects of Lysine deficiency, Lysine in pediatrics, blood proteins and many other subjects of interest to the professional personnel of hospitals. A bibliography completes the material. **(Key No. 3978)**

• **Emerson Resuscitation Hospital Equipment** is described and illustrated in a folder issued by J. H. Emerson Co., 22 Cottage Park Ave., Cambridge 40, Mass. Details of the new Emerson respiration dome are included as well as general information on the various models of respirators, Emerson hot pack apparatus and Emerson resuscitator, aspirator and inhalator. **(Key No. 3979)**

• Architects, administrators, building-equipment committees and those responsible for electrical maintenance in the hospital will be interested in the booklet recently issued by Crouse-Hinds Co., Syracuse 1, N. Y., entitled **"Explosion-Proof Electrical Wiring Equipment for Hospital Operating Rooms."** Text, diagrams and illustrations are used to give this information which includes National Fire Protection Association recommended safe practice for the use of combustible anesthetics in hospital operating rooms. **(Key No. 3980)**

• A **recipe service** whereby hospitals will regularly receive 4 by 6 inch recipe cards featuring quantity service of various Heinz products has been inaugurated by H. J. Heinz Co., Pittsburgh 12, Pa. Each recipe will be designed to serve 50 people and the back of the recipe cards will show suggested menus for complete luncheons or dinners featuring the food dish described in the recipe while every third recipe card will carry a colored photograph showing the finished dish. **(Key No. 3981)**

Dishwashing problems are constantly arising in any institution which serves food of any type. Thus the series of posters on this problem which has been prepared by Hobart Mfg. Co., Troy, Ohio, should be of interest to every executive or department head even remotely concerned with this detail. **"Sparkling Silverware"** is the title of the most recent release. Twelve and one half by 18 inches in size, printed on one side only on heavy paper so that it can be hung adjacent to the dishwashing machines, the poster shows every step in the proper washing of silverware for obtaining good results. Regular washing is pictured and each step briefly and clearly explained, alternate methods are suggested, toweling aid, storing, handling, detarnishing practices and burnishing suggestions are all included. Even a chart showing correct table arrangement of silverware is shown. The complete series to date, which includes a poster on the proper handling of tableware and detailed instructions for getting maximum use and value from dishwashing machines, is available on request. The instructions are applicable to any type machine and the series is designed to improve the quality of institutional dishwashing. **(Key No. 3982)**

• The complete lines of hospital bedside tables in both stainless and enameled steel, nurses' desks, chart racks and chairs in both stainless and enameled steel, and physiotherapy and hydrotherapy equipment in stainless steel are illustrated and described in three bulletins, **No. 1 BTC, No. 2 CDC and No. 6 HYC** respectively, issued by S. Blickman, Inc., Weehawken, N. J. **(Key No. 3983)**

• **Gomco Equipment** is described and illustrated in a folder issued by Gomco Surgical Mfg. Corp., Buffalo 11, N. Y. Complete instructions for use and care of Gomco Tidal Irrigator and Cystometer are given. **(Key No. 3984)**

• **"Water Hammer — Its Cause and Cure"** is the title of a 6 page booklet issued by Wade Mfg. Co., Elgin, Ill. Condensed facts, gathered from years of water hammer study by Wade engineers, are presented in easily understood language and the Wade Sealed Air Chamber as a solution to this problem is described. Also included are Selector Tables and Pressure Flow Charts for the use of architects, engineers and maintenance department heads. **(Key No. 3985)**

• **The New KMC Remington Typewriter** with keyboard margin control is described and illustrated in two full color brochures and a booklet issued by the Typewriter Division of Remington Rand, New York 10. The unique features of this machine plus its standard qualities are brought out in a manner which will prove interesting to those who use and those who purchase typewriters. **(Key No. 3986)**

• The Cleveland Range Co., 3333 Lakeside Ave., Cleveland 14, Ohio, has recently issued an attractive new 4 page catalog insert giving specific information on the **Steam-Chef compartment steam cooker.** The various sizes and models of both the direct connected type and the steam generating types which produce their own steam from gas or electricity are described with information on the performance of these cookers. **(Key No. 3987)**

• Factual information for users of these products is presented in the **"Ready Reference Chart, B-D Syringe, Needle and Hose Adapters and B-D Stopcocks and Valves"** available with the compliments of Becton, Dickinson & Co., Rutherford, N. J. **(Key No. 3988)**

• A complete new catalog covering its **"Laboratory Glassware"** has been issued by Corning Glass Works, Corning, N. Y. Identified as **Catalog No. LP28,** the 176 page book covers all standard items and a note attached to the cover invites inquiries for special apparatus. The line includes Pyrex Brand, Vycor Brand and Corning Brand laboratory and pharmaceutical glassware and the complex index under subject headings makes it easy to find details on any desired item without delay. **(Key No. 3989)**

Information on the preparation of **Green Spot Near-Freeze Pure Condensed Orange Juice or Grapefruit Juice** is offered in a leaflet issued by Green Spot Inc., 658 Mesquit St., Los Angeles 21, Calif. The ease of preparing these juices for serving, their fine quality and careful processing are some of the subjects covered. **(Key No. 3990)**

• An attractive booklet on **"Humidity, Its Necessity and How to Obtain It"** has been issued by Walton Laboratories, Inc., Irvington 11, N. J. The reasons for humidifying the air and the Walton humidifiers and their action are subjects covered in the booklet. **(Key No. 3991)**

**"The abc's of Wyandotte Wax"** is the title of a folder published by Wyandotte Chemicals Corporation, Wyandotte, Mich. Helpful information on Wyandotte Wax and its use on all types of finished floors is presented. The detailed directions include the maintenance of both large and small areas. **(Key No. 3992)**

• Application, construction details, dimensions, ratings and general information on **Webster Type WI Extended Surface Radiation** are given in **Bulletin BB 1550A** issued by Warren Webster & Co., Camden, N. J. Descriptive details, photographs of the product and of installations and diagrammatic drawings are included. **(Key No. 3993)**

• Two new leaflets have been issued by Liquid Conditioning Corp., 114 E. Price St., Linden, N. J. **Bulletin 10** deals with the prevention of scale formation and corrosion in the water used for equipment cooling and **Bulletin 11** deals with continuous boiler blowoff to reduce the concentration of dissolved solids in the boiler. **(Key No. 3994)**



***Address manufacturers for further information and prices—or use Readers' Service blank on page 248***

## Book Announcements

**The Blakiston Co., 1012 Walnut St., Philadelphia 5, Pa.** Hawk, Oser & Summerson, "Practical Physiological Chemistry," 12th Ed., 1323 pp., $10. **(Key No. 3995)**

**Hospital Textbook Company, 99 Wall St., New York 5,** Hayt, Emanuel, LL.B., and Hayt, Lillian R., M.A., J.D., "Law of Hospital, Physician and Patient," 688 pp., $7.50, prepared in collaboration with American College of Hospital Administrators. **(Key No. 3998)**

**The Macmillan Company, 60 Fifth Ave., New York 11,** Burdon, "Textbook of Microbiology," 3rd Ed., 727 pp., $3.50. . . . Goldwater, Sigismund S., M.D., "On Hospitals," 384 pp., $9. . . . Morse, Edna Curtiss, R.N., A.M., Ed.D., "College Chemistry in Nursing Education," 260 pp., $4. . . . Smillie, Wilson G., A.B., M.D., Dr.P.H., "Public Health Administration in the United States," 3rd Ed., 664 pp., $6.50. **(Key No. 3996)**

**C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Mo.,** Jensen, Deborah MacLurg, R.N., B.S., M.A., "Introduction to Sociology and Social Problems," 3rd Ed., 480 pp., $3.75. . . . Top, Franklin H., A.B., M.D., M.P.H., F.A.C.P., "Communicable Diseases," 2nd Ed., 947 pp., $9.50. **(Key No. 3997)**

**W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa.,** Adler, Francis H., M.D., "Gifford's Textbook of Ophthalmology," 4th Ed., 512 pp., $6. . . . McCombs, Robert Pratt, B.S., M.D., F.A.C.P., "Internal Medicine in General Practice," 2nd Ed., 741 pp., $8.50. . . . Wechsler, Israel S., M.D., "A Textbook of Clinical Neurology," 6th Ed., 829 pp., $8.50. **(Key No. 3999)**

**TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.**

**Bessie Covert,**
**Editor, "What's New for Hospitals"**

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- ☐ 3935 Improved Kotex Pad
- ☐ 3936 Nurse-Patient Communication
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- ☐ 3938 Portable Intravenous Stand
- ☐ 3939 Instrument Sterilizer
- ☐ 3940 Hemostatic Surgical Dressings
- ☐ 3941 Electroconvulsive Unit
- ☐ 3942 Filmo 8 mm. Camera
- ☐ 3943 Universal Infusion Standard
- ☐ 3944 Colt Autosan R-100 Dishwashing Machine
- ☐ 3945 Plibrico Portable Incinerator
- ☐ 3946 Sperzel Toilet Seat
- ☐ 3947 Eastman View Camera
- ☐ 3948 Public Room Furniture
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- ☐ 3950 Pictronic 200 Timeter
- ☐ 3951 Westinghouse Water Coolers
- ☐ 3952 Dazor Floating Magnifier
- ☐ 3953 Vestal Wax Remover
- ☐ 3954 Rubberized Dampcoat Enamel
- ☐ 3955 Lawson 200 All-Service Can
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- ☐ 3984 Gomco Equipment
- ☐ 3985 "Water Hammer"
- ☐ 3986 KMC Remington Typewriter
- ☐ 3987 Steam-Chef Catalog
- ☐ 3988 "Reference Chart"
- ☐ 3989 Catalog No. LP28
- ☐ 3990 Green Spot Juice
- ☐ 3991 "Humidity"
- ☐ 3992 Wyandotte Wax
- ☐ 3993 Bulletin B 1550 A
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**MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.**
**919 N. Michigan Ave., Chicago 11, Ill.**

## Suppliers' Plant News

**Pittsburgh Corning Corp., 632 Duquesne Way, Pittsburgh 30, Pa.,** announces the opening of a new plant at Sedalia, Mo., for the production of glass blocks. **(Key No. 4000)**

**The Jackson Dishwasher Co., 3703 E. 93rd St., Cleveland 5, Ohio,** manufacturer of dishwashing machines, announces the opening of a sales and service office to serve the Illinois territory at 506 S. Wabash Ave., Chicago 5. **(Key No. 4001)**

**Everest & Jennings Co., 7748 Santa Monica Blvd., Los Angeles 46, Calif.,** manufacturer of folding wheel chairs, wheel chair accessories and allied items, announces the opening of its new modern building doubling the former size of the plant. **(Key No. 4002)**

**The Wm. S. Merrell Company, Cincinnati 15, Ohio,** manufacturer of pharmaceutical products, announces the opening of two new distribution depots, one in Atlanta, Ga., and the other in Bloomfield, N. J., to give faster and more efficient service to customers in the Southeastern and Middle Atlantic areas. Both new depots will stock a complete line of Merrell specialties. **(Key No. 4003)**

**Johns-Manville Corporation, 22 E. 40th St., New York 16,** announces the opening of the first laboratory and pilot plant building of their Research Center group located near Manville, N. J. The project will be devoted to research in building materials, insulations and allied industrial projects. The new J-M Research Center, when completed, will consist of five or six buildings grouped around a quadrangle. The first building, just opened, will be devoted to research and development involving wet processes and will contain 10 miniature factories or pilot plants, each connected with its own laboratory, thus permitting all experimental production to be completed before the product is sent to a J-M factory for mass production. **(Key No. 4004)**

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